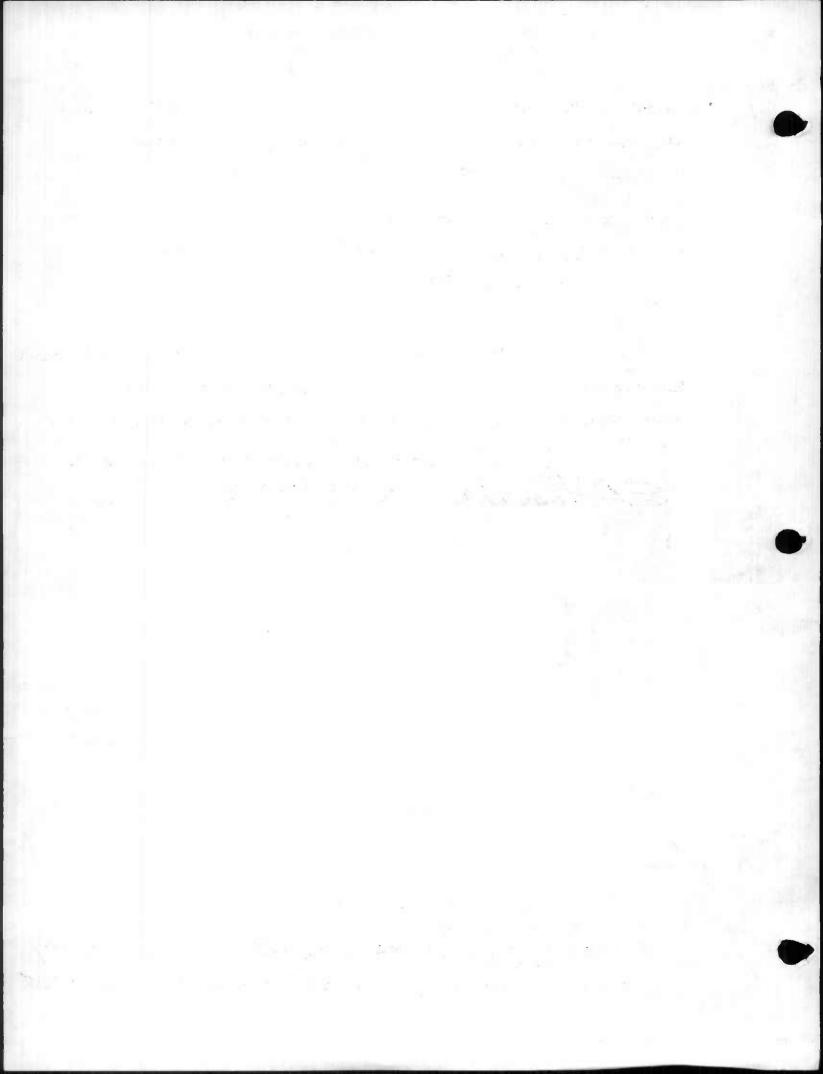
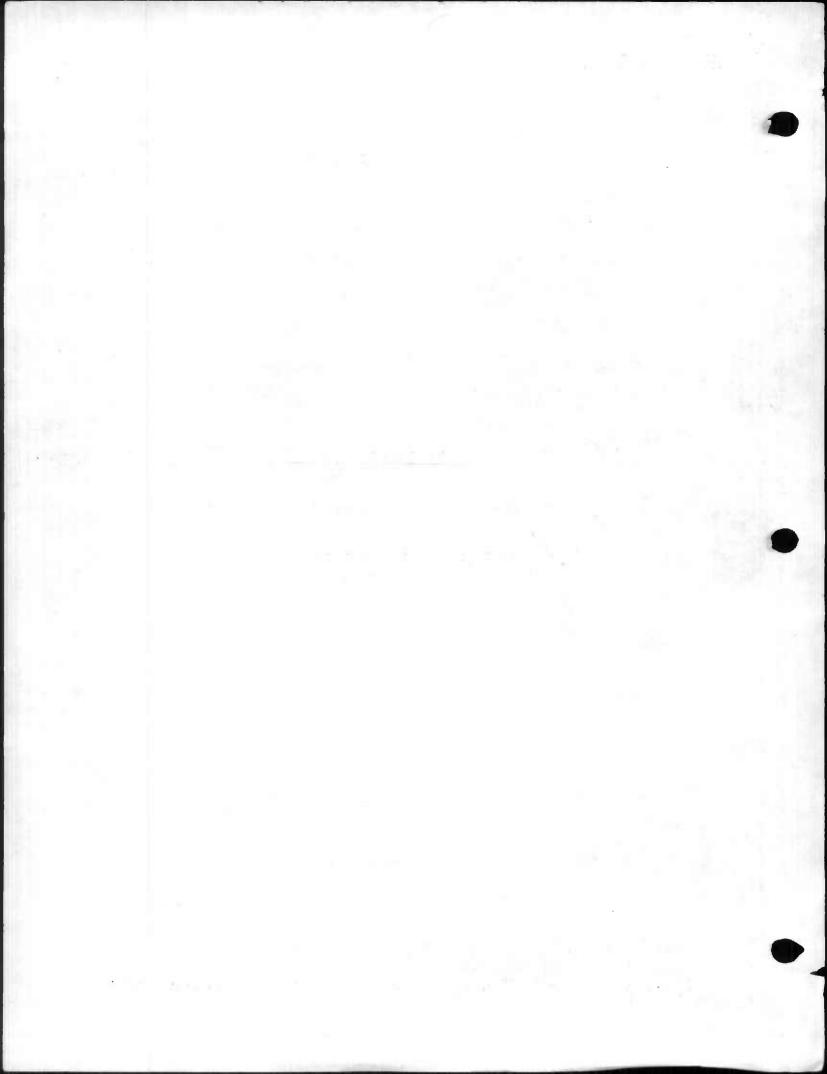
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State of Maryland / Department of Health and Mental Hygiene

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	Physic	ian	1. Dacedant's Nama (First, Middla, L	ast)						2. Date of D Month	aath Day	Yaar	3. Tima of Death		
	/Medi		Harold C. Ray							March			9:00AM		
)	Exami	ner	4a. Facility Nama (If not institution, g	iva straat and numbar)				4b. City, To	own, or Lo	ocation of Daa	th 4c. Cou	nty of Death			
			11805 Franklinvi					Upper	Fall	ls	Balt:	Lmore			
	Funeral			1MM 2DE	a (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Data of B (Month, D May 17	irth ay, Year)	9. Birth	placa (Stata or Foreign ntry)		
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land	M W		10a. Stata 10b. County		10c. City, T	own or Lo	cation					1.	10d. Insida City Limits		
Man	1	ţō	Maryland Baltimon	ce	Upper	Falls	S						1 ☐ Yas 2 No		
h the	r 28g	rec	10e. Street and Number				10f. Zip Coda				10g. Citizan o	of What Cou	ntry?		
h wit	23a o	a D	11805 Franklinvi	lle Road			21156				U.S.A.				
dea	E H	Funeral Director	11. Marital Status	12. Was Decedant if Armed Forcas?		13. V	Vas Dacedant of I Yas, specify Cub	Hispanic Or	igin? (Sp	ecify Yas or N		ace - Amari			
Ind 21215-0020 be filed within 72 hours efter death with the Manyland	or it		1 ☐ Navar Married 2 ☐ Married	1 Vas 2 □ N	_{√o} ARMY		☐ Yas 2 X No			ricali, atc.		lack, Whita,	atc.		
000	Ex	d by	3 XWidowed 4 ☐ Divorcad	1945/194	46					Spe		ite			
21215-0020 d within 72 hours eff	"net	Completed	15. Decedant's E (Specify only highast g	Education ra <i>da complated)</i>	1	6a. Deced (Give	ant's Usual Occu kind of work dona OO NOT usa retire	pation during mos	t of work	ing	16b. Kind of	Businass/In	dustry		
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	ental cad o c ev	To Be										,			
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	Health e am 27 is ther trai		Beverly Raymond	(Daughter			Frankli						. 21156		
s ta	of Hear Item		20a. Mathod of Disposition				sition (Nama of natory or other pla			Data	20c. Locatio				
Baltimore,	Deperment of Health end Mental thygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumetic event, the Medical Examiner must be normed at once.	- 1	1 Burial 2 □ Cramation 3 I 4 □ Donation 5 □ Other (Spac	□Ramoval from Stata ify)			Baptist		sch 3	1/29/99	Randal	letow	n MD		
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J sign	i bell														
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Physicia		1. Decedent's Name (First, Middle,		Certifica	ale Of I	Dealn		Date of De Month	Day	Year	3. Tima of Death
/Medic	al -	4a Facility Name (If not institution,	J. MITA			4b. City, To		MARCH tion of Deat			3:30 PM
Examin	er	557 CHESTNUT					EST HI		Ha	Rfoi	ed
Funeral Director		5. Social Security Number 212 - H2 - H456 Usual Residence of Decedent	6. Sex 7. Age (In 1	yrs. last birthday) If Un Month	hs Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Bir (Month, Da	th 21.1944	9. Birth Gou	nplace (State or Fore unitry) 2 kyland
Ba-f show Milled at	- 1	10a. State 10b. County Md Hal	ford F	City, Town or Location ORIST Hill	l						10d. Inside City Lim 1 ☐ Yes 2 ☐
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Framinar	þ	1 Never Married 20 Married 3 Widowed 4 Divorced	Armed Forces?		specify Cube s 201No	an, Mexican Specify:	, Puerto Ri	ty Yes or No can, etc.)	Specify Specify	ck, White	
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nd Mental Hyglene. marked other than imatic event, me	To Be	17. Father's Name (First, Middle, L	Their SR.			B	erth	a C	Maiden Suman		
Department of Health end mportant: if Item 27 Is my any injury or other traum bace.		19a. Informant's Name/Relationsh 20a. Method of Disposition	th husban	19b. Mailing Addr 557 C Ob. Place of Disposition (incremetery, crematory)	Mast A	yut H	ill R	d. Fo	PLST H	10/	4d 2105
Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		Deer Treek Co		1 4 1	atk 1	999	FOREST	- Hel	le Mary
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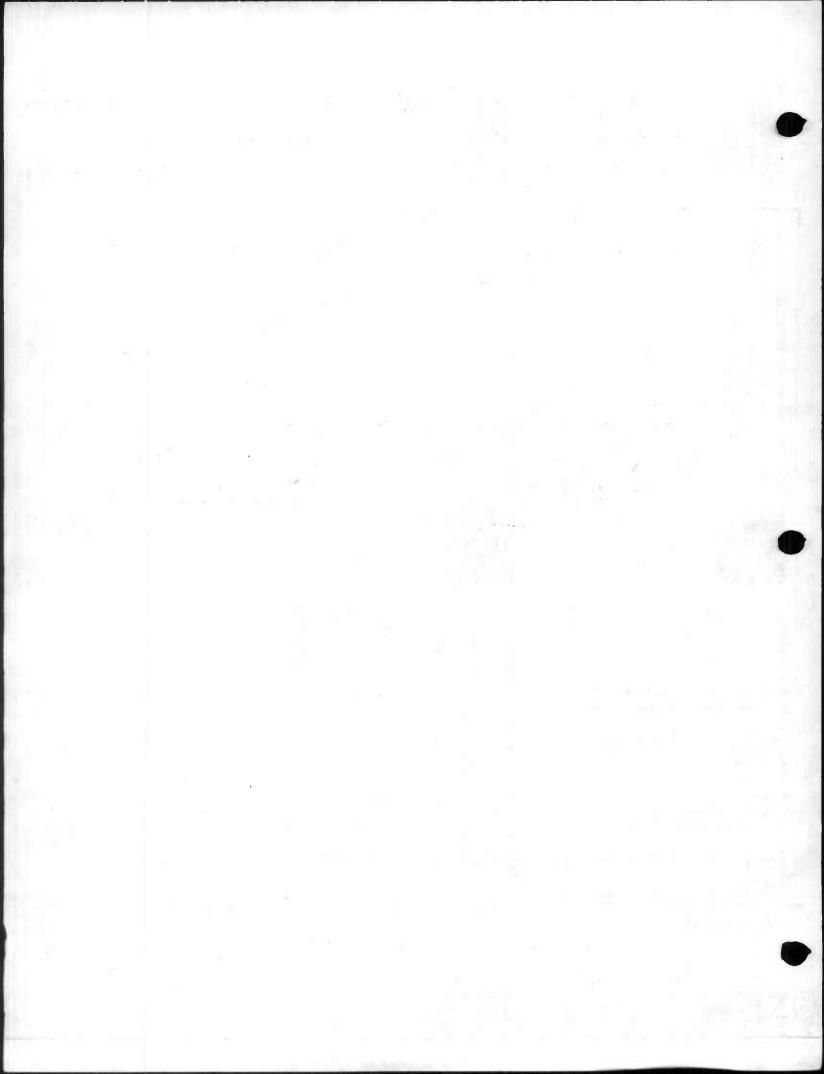
State of Maryland / Department of Health and Mental Hygiene

10503 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Daath Month Day Yaar 9 SCHWARTZMAN FRED **Physician** /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Church Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. AUG 31, 1936 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) Birthplaca (Stata or Foraign Country) **Funeral** 1√ M 2□ F Months 212-34-7188 62 Yrs. Director Maryland Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examener must be notified at the Man MD N/A Baltimore Director 1 Yas 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? with 1 235 S. Spring Court 21231 Funeral USA death v 12. Was Dacedent Evar in U,S. Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumetic event. Armed Forces?

1 Yas 2 No
If Yes, Giva
Yaar or Datas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: by 3 ☐ Widowad 4 ☐ Divorcad Specify: White Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Grounds Keeper Baltimore City 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be Albert Schwartzman Helene Holtschneider 70 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Henry R. Schwartzman/brother 2504 Thornberry Dr. Edgewood, MD 21040
a of Disposition (Nama of Data 20c. Location - City or Town, Stata 20b. Pleca of Disposition (Nama of camatary, crematory or other pleca) 20a. Mathod of Disposition 1 ☐ Bunal 2 ☐ Xremation 3 ☐ Ramoval from Stata Metro Crematory, Inc. 4/1/99 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore, MD 21. Signature of unaral Sarvice thouses ²² Name and Address of Facility Cremation Society of Md., Inc. Edward A/ 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar tha disaasa, or complications that caused tha daeth. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart failure. List only one ceusa on each line. **Physician** /Medicai Immediata Causa (Finel MYOCARDIAL ENPARCTION HOVAS disaase or condition rasulting in daath) Examiner Physician/Medical Examiner The law requires that the death certificate be asscuted physician and s the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cousa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760, Dua to (or as a consequence of): for use es ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? - DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown - CHRONIC OB STRUCTIVE LING DISEAS performed? 24b. Ware autopsy findings eveilabla prior to completion of ceuse of death? -0BESITY. 1 Yes 2 No 1 Yas 2 No ospital or Attending Physician: Theoris after death.

uneral Director: After this certificately filled in by the funeral director, pt 25. Was cesa refarrad to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 70 1 Yas 2 No 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 28d. Dascribe how Injury occurred 1 Natural 5 Panding Invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Phyalcian: To the best of my knowladga, daath occurred at tha tima, deta and place, end dua to tha causa(s) and mennar as stated.

2 Madical Examiner: On tha basis of axamination and/or investigetion, in my opinion, daath occurred at the tima, data end place, and due to tha cause(s) end manner stated. Medicai (Check only one) 29b. Signatura end titla of certifier 29c. Licanse number 29d. Data signed (Month, Dey, Year) 017322 MARCH, 31, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) -8. NAZEMI, M.D. CHURCH HOSPITAL BACT. ME 31. Data filad (Month, Day, Year) 32. Registrar's Signetura APR 0 1 1999 Registrar DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Nama (First, Middla, Last) 2. Data of Deeth MARY LOU SOKOLOVE Month 30 99 4:50 P.M 4a. Facility Nema (If not institution, give straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Church Hospital RALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foraign Country) 1□ M 2 F Months Yrs 422-22-1070 85 NOV 21, 1913 Mississippi Usual Rasidance of Decadant 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 811 S. Montford Avenue 21224 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 █ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Yas, Giva White Specify: 3 ₩ Widowed 4 Divorced 15. Decedant's Education (Specify only highest grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collaga (1-4or 5+) Self-employed Artist 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Meiden Surnama) Edward Fletcher Watkins Ina Gray 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) Shirley S. Albert/Daughter 1212 Dulaney Valley Road Towson, MD 21286 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Spacify) Metro Crematory, Inc. 3/31/99 Baltimore, MD 21. Signature of Funaral Sarvice Licensaa 22. Name and Address of Facility Cremation Society of MD, Inc. Edward Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Entar the disaasa, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Intervel Batween Onsat and Death Immediata Cause (Final diseasa or condition rasulting in death) SEPSIS 24 /4/2 Dua to (or as a consequence of): Unin any Train Infection Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Diseesa or injury thet initiated events rasulting In daath) Lest Dua to (or es a consaquence of): Due to (or es a consaquance of) Pert il. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy 2 No 1 Yes 1 Yas a No 25. Wes cese rafarrad to medical axaminer? 26. Placa of Daath (Check only ona) Hospital: 1 Yas 2 No 1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 DNaturai 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Physician/Medical Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician on completely filled in by the Inneral director, page 2 should be detected for use es the bunkal-transit Box 68760, P.O. Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

23s or 28s-f show must be notified at

Directo

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Completed

Be

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Pages 1 and 2 should ment of Health and Man

ä item 27 i

Important: If it any injury or o

Physician

/Medical

Examiner

Be Completed Certification: To

Medical

State Registrar

31. Data filed (Month, Day, Year) APR 0 1 1999

4 Homicida

29b. Signatura and titla of certifian

13

29a. Cartifia: (Check only one)

Chary M.O. 30. Name and address of person who complated ceusa of death (item 23e) (Type, Print)

ELMA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date end piace, end due to the ceuse(s) and mannar steted. 29c. License number 29d. Data signed (Month, Day, Yaar)

M.D. CHERREH HOSPITAL 100 N. BROADWAY

3 Registrer's Signatura

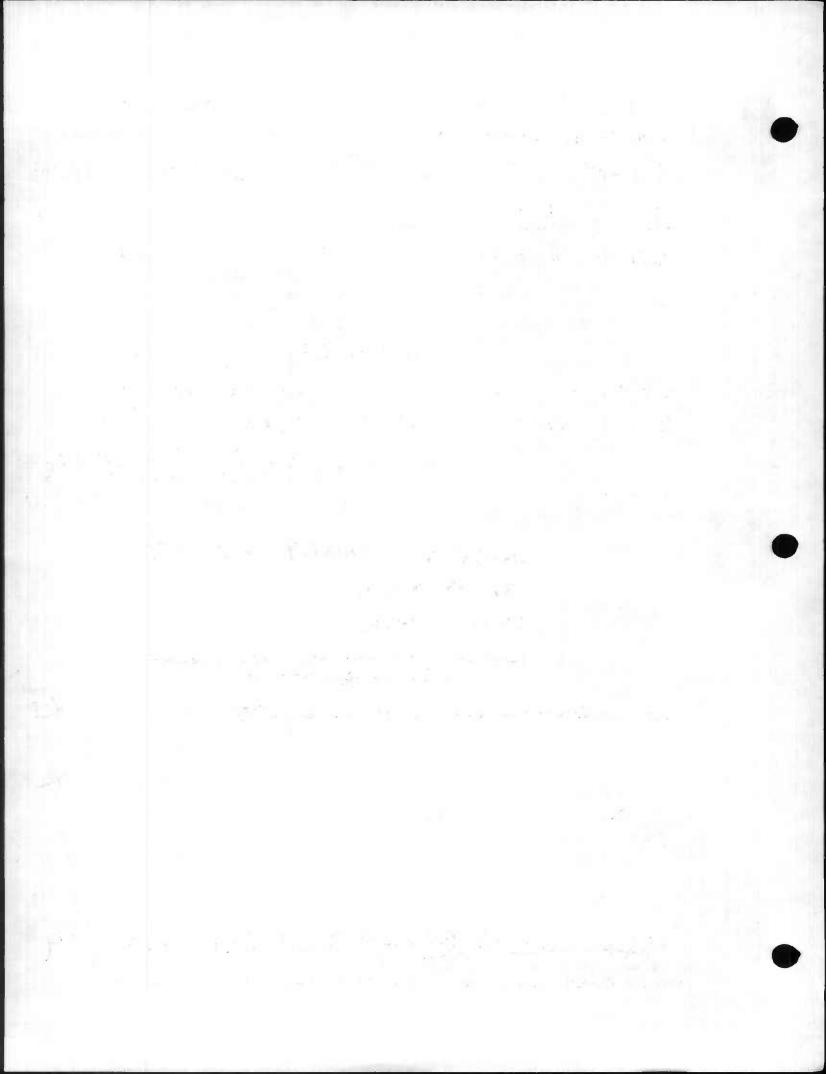
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tate of Maryland / Department of Health and Mental Hy	giene	99	15		1
Certificate of Death	Reg. No.				

				Certificate of	Death	Reg	g. No.	
Physiciar	_	1. Decedent's Neme (First, Middle, Last)				2. Dete of Death Month	Day Yea	
/Medica	ıl -	Edna M. Spar	111		4b. City, Town, or Lo	MARCH vestion of Death	29, 199 4c. County of De	
Examine	r	4a Facility Name (If not institution, give street and number Saint Joseph Medical			Towso	n	Bal	timore
Funeral Director		5. Social Security Number 219-01-9903 6. Sex 1 M 20 F 7. Usual Residence of Decedent	Age (In yrs. last I	oirthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,)	1920 P	Birthplace (State or Fore Country) LNNSYIVANI
or 28a-1 show		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Lim
th with th	Funeral Director	10e. Street and Number 2034 Mt. Holub Rd	1	10f. Zip Code	154	10	g. Citizen of What	Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mantal Hygiana. Rem 27 is marked other than "natural", or flores 23s or 28s-f show other traumatic event, the Mad all Examinat must be notified.	by Funer	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decede Armed Force 1 Yes, 2 of the Yeer or Date		13. Was Decedent of If Yes, specify Cul		ecify Yes or No- Ricen, etc.)	14. Race - Ar Black, W Specify:	11-1
"natural",	Completed by	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedent's Usual Occu (Give kind of work done	during most of work	ing 10	6b. Kind of Busines	ss/Industry
within ana.	E C	Elementary/Secondary (0-12) College (1-4c	or 5+)	life. DO NOT use retin	J 0 D		homo	
should be filed within the Mantal Hygiana. marked other than imatic event, the Mantal Hygiana.	Se l	17. Father's Neme (First, Middle, Last)		101011an	18. Mother's Nem	e (First, Middle, M.	aiden Surname)	
should be nd Mantal marked o	0	Carvel L. ENSON	e		Blan	che Si	oaldin	9
2 sho		19a., Informant's Name/Relationship (Type, Print)	11	9b. Mailing Address (Street	et end Number or Run	al Route Number	City or Town, State	a, Zip Code)
s 1 and f Haalth kam 27 other tr	-	20a. Method of Disposition	20h Piece	of Disposition (Name of	Moren Ka	Date 2	Oc. Location - City	or Town State
0 = 5		1 Burial 2 Cremetion 3 Removal from Sta		tery, crematory or other pl	ace) R. Inin	larch 31	FRANCE H	M Hazula
in the	+	4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee	LVan	22. Name end Addi	ess of Facility Cu	1999 H	MORISTA	Willy - Pal
Ded I se		* Horala . 11	10/1/2	3 110	ANT DA	Es sol	H. 11 1	12 21051
	1	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. D	o not enter the mode of dy	ring, such as cardiac	or respiretory arres	st,	Approximete Intervel Between
hysician								Onset end Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting In death)	DIOPL	LMONA	rry 1	ARRE	ST	
COLUMN TWO			Due to (or es	a consequence of):				
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ding physician and ise es the buriel-transit	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		a consequence of):				
ysicla	Z Z	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):		~		
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attandii for use	200	d	di	multi	mene	1		7.00
9 6 6	Physician	Part tl. Other eignificent conditione contributing to death	but not resulting	In the underlying couses	iven In Part I	23b. Did tob	pacco uae contrib	ute to the cause of dea
	7	Carebroros	ula	- Acc	Dent	1 10 Ye	• 2□No 3□	Probably Unkn
law requiras as been sign 2 should be	Completed by					24a. Was an perform		lb. Were autopsy finding available prior to completion of ceuse of deeth?
Tha law ata has paga 2	E					1 ☐ Yes	NO NO	1 ☐ Yes 25(No
	De C	25. Was cese referred to medical examiner?				h (Check only one)	
	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpe		Jutpatient 3LI DOA			nce 6 Other (S	ipecify)
octor: Aftar by the funer	ion i	Top Patter S E Torionis	Day Year)	Time of 28c. Injury W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
daath.	Ica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Injury - At home.	farm, street, factory, office		28f. Location (Stre	eet and Number or	r Rural Route Number,
d in b	Certification:	4 Homicide determined building,	etc. (Specify)	,		City or Town,	State)	
	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basis and menner	of examination					
To th comp	-	29b. Signeture and title of certifier	0	M , 29c. Licer	nse number	29	d. Date signed (Me	onth, Day, Year)
		Marine 13	, les	and D S	39126	0	3/30	799
		30. Name end eddress of person who completed cause of	of death (Item 23e	(Type, Print)			1	(, ,
				LER DRIVE	TOWSON,	MARYLAN	ND 21204	+
State	9	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature					

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year 27, GLORIA MAE STRAITZ MARCH 1999 3:00 A.M. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 409 GLENWOOD AVENUE GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Months Hours 1 ☐ M 2 🖺 F 215-24-5853 Jan. 5, 1928 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Glenwood Avenue 21061 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, atc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Supervisor State Government 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Phillip Harrison Disney Edna Mae Neilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Wayne A. Straitz / Son 479 Hawk Ridge Lane, Sykesville, Maryland 21784 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Baltimore National Ceme 3/31/99 Baltimore, Maryland 21. Signetare of Funeral Service License HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MARYLAND 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Finel disaasa or condition resulting in death) 5mos Cancer Due to (or es a consequence of) Dua to (or as a consequence of). Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

72 hours after

permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene important; if ham 27 is marked other than "r. eny injury or other traumatic event

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Examin physician and s the bunal-transit that the death certificate be executed Physician/Medical 50 980 the 2 Completed hes page certificate Be edical Certification: To After this To the Hospital or Attending Pt within 24 hours effer deeth.
To the Funeral Director: After th completely filled in by the funeral

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Box 68760,

P.O.

Records,

Division of Vital

Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

1 Yes 2 No 1 Yes 2 No 25. Was case raferred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Rasidence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred 5 Pending investigation 1 Maturel Injury 1 Yas 2 No 2 Accident 6 Could not be datamined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier

(Check only one)

19 Certifying Physician: To the best of my knowledga, death occurred et the time, date end place, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted.

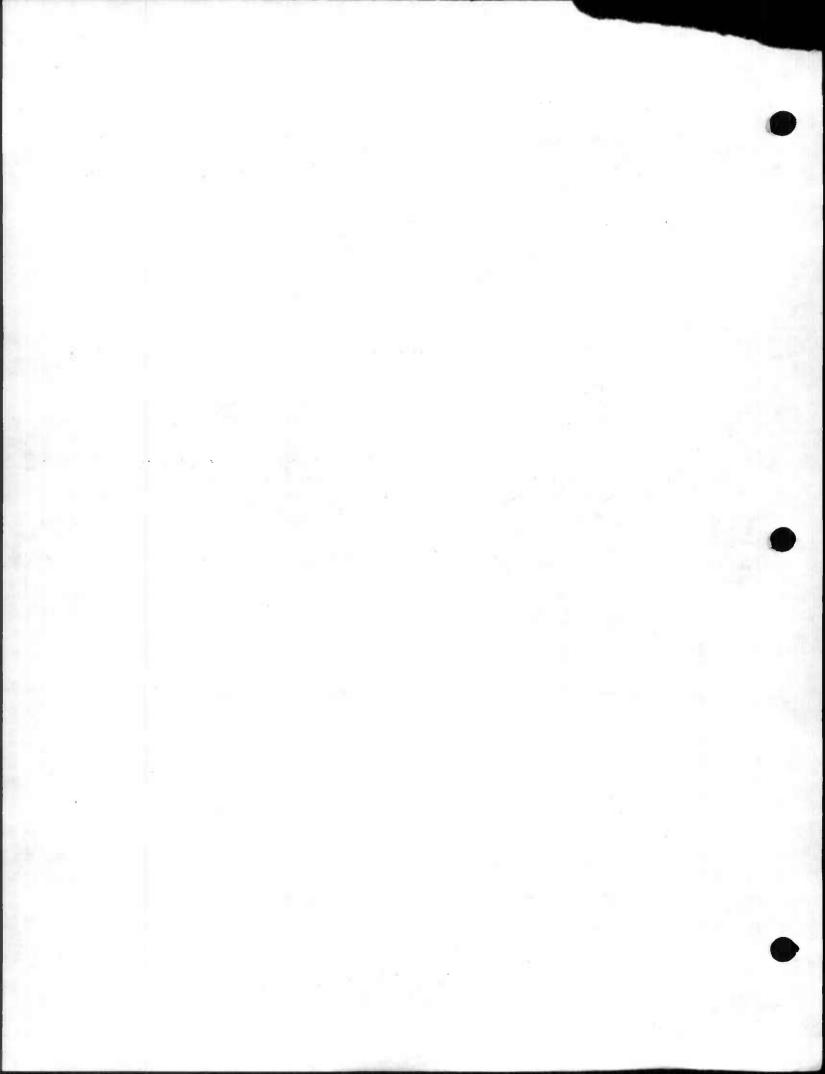
29b. Signature and title of certifier maga 29c. License number 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death them 23e) (Type Print) E 602

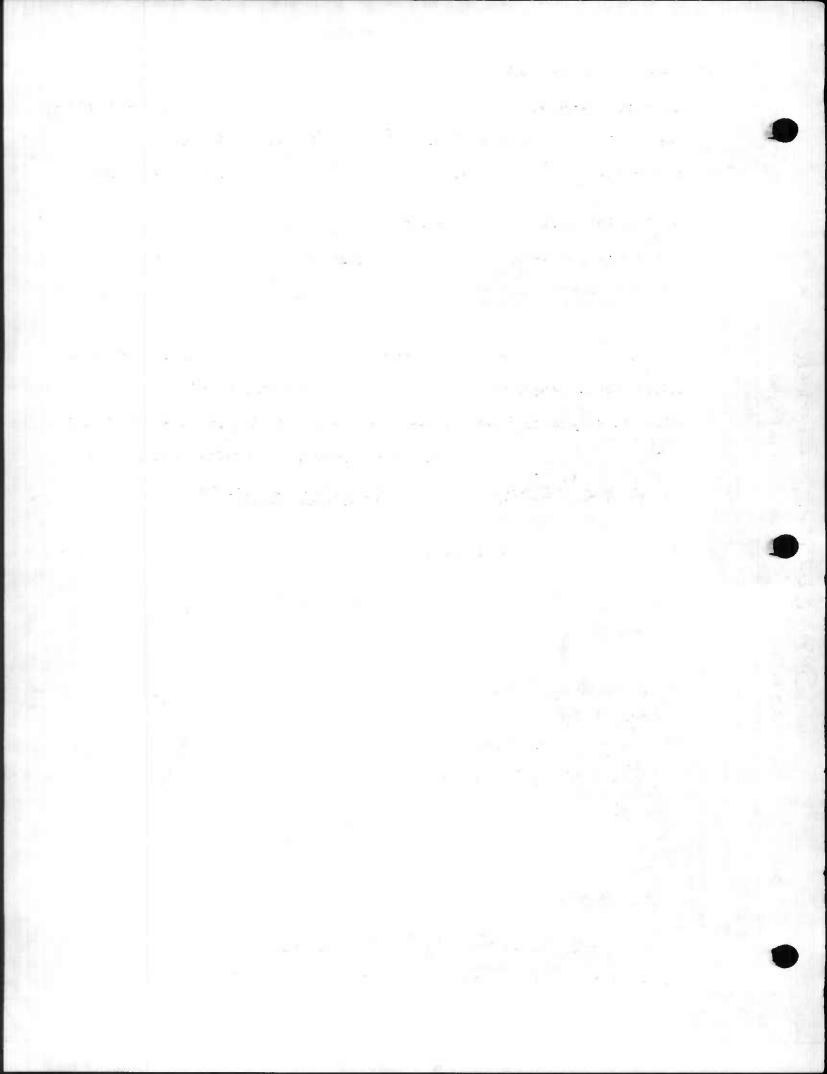
DR. RUSSELL DeLUCA -1600 CRAIN HIGHWAY, GLEN BURNIE, MARYLAND 21061

State Registrar 31. Dete filed (Month, Day, Year) 1 1999 APR

Registrer's Signeture

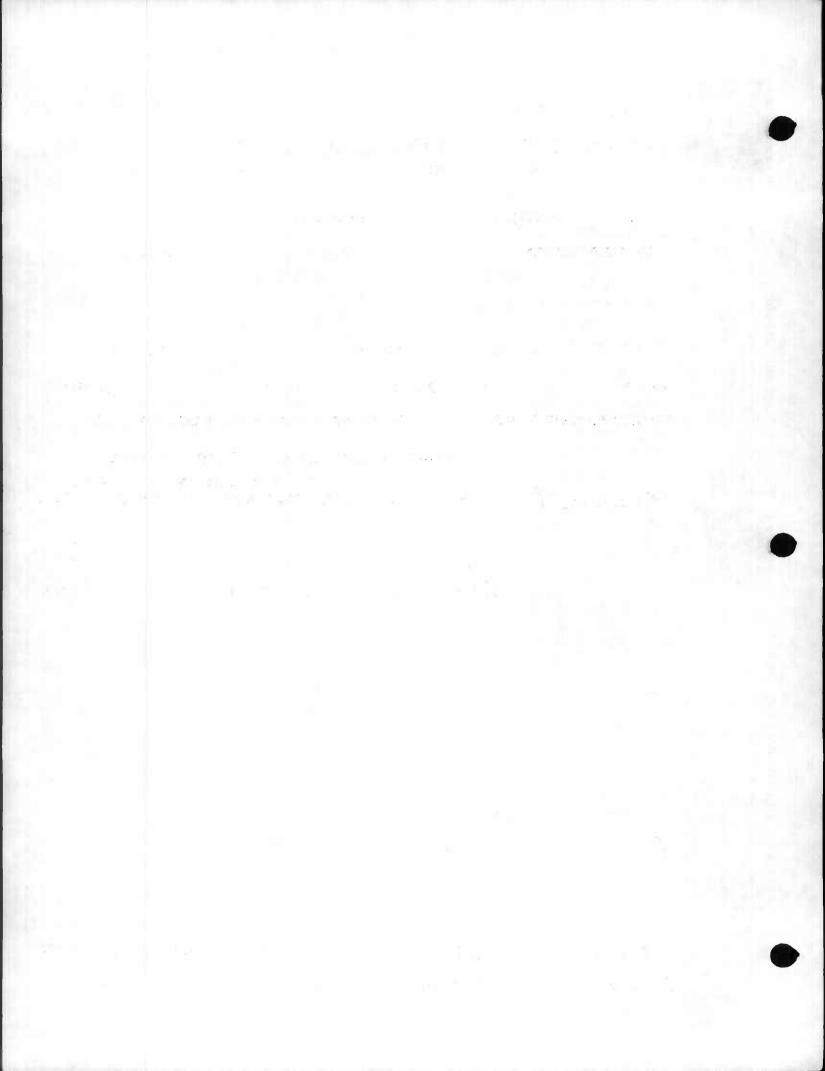


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FULL	Physician - /Medical	Elmer Carl Sens	ebusch					Month	21 +	497 10°	32n	
	Examiner	4e Fecility Neme (If not institution	n, give street and number,)	1		4b. City, Town,	or Location of De	th 4c. County	of Death	19	
		CATON MANO	R GENESIS	5 ELD	ERUA		DALTIM		7			
	Funeral	5. Sociel Security Number	6. Sex 7. A		est birthday) Yrs.	Months Dey		Ain. (Month, I	Sirty Day, Yeer)	Birthplece (Stet Country)		
	Director	215-18-7624 Usual Residence of Decedent		75	115.			Sep. 8	, 1923	Maryland		
	Mand war	10e. Stete 10b. County		10c. City	, Town or Loc	ation				10d. Inside	City Limits	
	Man	Maryland Baltin	nore	Balt	imore					1□Y	es 2 No	
	or 28.	10e. Street end Number				10f. Zip Code	a .		10g. Citizen of	Whet Country?		
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20	call, or thems:	1 Nevar Married 2 Man	1 Nevar Married 2 Married 1 Yes 2 New Married 2 Married 1 Yes 2 New Married 1 Yes 2 N				lo Specify:		Specif	White	4	
5-0020	be filed within 72 hours efter deeth with the Maryland tal hygiene. Ital hygiene. Other than "natural", or items 23a or 28a-f show event, the Marical Exactions must be notified at event, the Marical Exactions from the notified at Be Completed by Funeral Director.		t's Education		16e. Deceda	ant's Usuel Occ	cupetion		16b. Kind of B	usinass/îndustry		
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ō	tal or Attending P rs efter death. al Director: After t led in by the funer Certification:	building, etc. (Specify) City or Town, State)										
	To the Hospital or Attending Physician: The lew requires that the death certificate be exemine 24 hours after death. To the Funeral Directors this certificate has been signed by the attending physician e completely filled in by the funeral director, page 2 should be deteched for use as the burial-Medical Certification: To Be Completed by Physician/Medical Ex	(Check only 2 Medical	g Physician: To the best Examiner: On the basis	of examinet	vledga, daath ion end/or Inve	occurred et the	time, date end p	lece, end due to the	ne cause(s) end m a, data and place,	enner as stated. and dua to tha ceus	sa(s)	
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(-)		30. Nama and eddrass of person C-V - CYRIAC -	MD 8109	RIT	CH 1/2	HWY,	PASA	DENA,	40 211	122		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Mary	-			ealth and Death	Mental Hy	giene 9 9		0508	
ian cal =	1. Decedent's Name (First, Middle, Last Charles M. S	doman					2. Dete of De Month March	29 1	Yeer 999	3. Time of De	
	le Fecility Neme (If not institution, give Local Security Number 217-34-6647 Usual Residence of Decedent	Mary land	Medical yrs. last birthday, 62 Yrs.	If Onde Months	ntr er 1 Year	Balt Hunder 24 Hr Hours Mir	1. (Month, De	N/A	9. Birthpl	ece (State or Fo	
	10a. Stete 10b. County	10	c. City, Town or L	ocation			L		10	od. Inside City L	
Director	MD BAL	FIMORE		BA	ALTIM	ORE				1 Yes 2	
	10e. Street and Number 2312 SUGARCONE RO	OAD		10f. Z	ip Code 2120	9		10g. Citizen of V		try?	
	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S. 13.	Was Deci if Yes, sp 1 Yes		ispenic Origin? (n, Mexicen, Pue Specify:	Specify	e - America ck, White, e			
	15. Decedent's Edit (Specify only highest gred Elementery/Secondery (0-12)	cation	16e. Dece (Give life.	kind of w DO NOT	ork done d use retired	ation funing most of w	orking	16b. Kind of Bu		lustry	
	7. Fether's Neme (First, Middle, Last)					18. Mother's Ne	eme (First, Middle				
	ADOLPH		SOLOMO			SYLVIA				CHKIND	
	19e. Informent's Neme/Reletionship (T) BERNICE SOLOMON						Ru <i>ral Rou</i> te Numb - BALTIM		2120	_	
-	20e. Method of Disposition 1 Durial 2 Cremetion 3 4 Donetion 5 Other (Specify)	Removel from Stete	Ob. Piece of Disposemetery, cre	osition (Na metory or	eme of other plea	e)	Dete 3/31/99	20c. Location - BALTIM			
	21. Signature of Funeral Service Licens	99						NSON & BROS., INC. PIKESVILLE, MD 2120			
edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of):										
	Pert il. Other eignificant conditions co	ntributing to death but no	ot resulting in the	underlying	causa giv	en in Pert I.	23b. Dld	tobacco use co	ntribute to	ribute to the cause of death	
		and the death but he	A TOO SHITTING TO THE		oodso giv		1 Yes 2 No 3 Probably				
Parallelle					_			s en eutopsy ormed?	eve	ere eutopsy find allable prior to appletion of ceu- deeth?	
D	25. Was case referred to medical					26 Blace of D	1 □ eeth (Check only	Yes 2/25/No	10	Yes 2 No	
ToB	exeminer?	lospital: inpatient 28e. Dete of Injury (Month, Day Ye	2 ER/Outpatie		OOA Oth	er: 4 Nursing	Home 5 ☐ Res			1)	
	2 Accident investigation 3 Suicide 6 Could not be determined	Yes 2 □ No	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)								
100	29a. Certifier Check only one) Certifying Phy	alclan: To the best of my ner: On the basis of exa end manner stated.	y knowledge, deal mineti <i>on</i> end/or in	th occurre	d et the tin	ne, dete end pie pinion, deeth occ	ce, end due to the curred et the time	ceuse(s) end mo	enner es st end due to	eted. the cause(s)	
- (29b. Signeture and title of certifier	1.4		2	9c. Licens	e number	- 1	29d. Date signe	d (Month, i	Dey, Year)	
-	10. Name end edd/ess/of person who co	ompleted ceuse of deeth	(Item 23a) /Tune	Print)	P-	1239	70	March	29)1999	
)	Celly AEllis.	22 8. 0	green S	Pres	+ 1	Paltim	ore	MD 2	120		
e ar	31. Dete filed (Month, Dey, Year) APR 1 19	32. Registrar's	Signeture	. 1	pork	2					



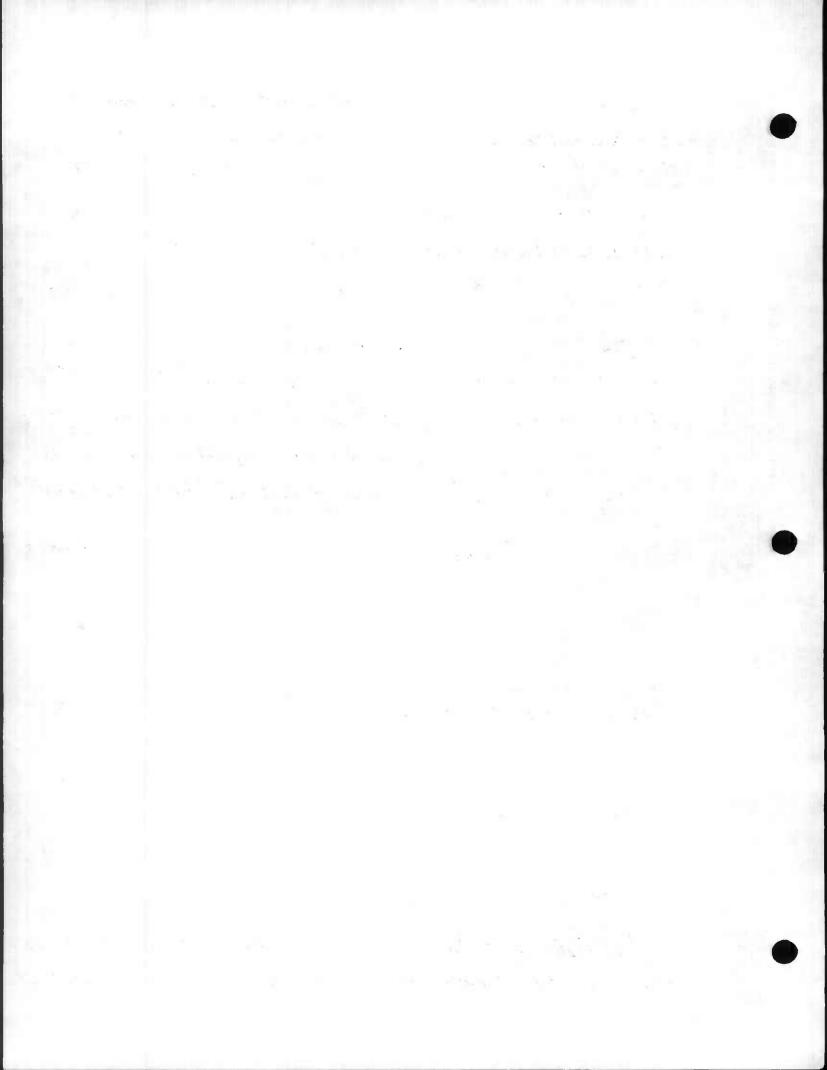
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth MARCH **Physician** 30^{Dey} 22:05 SEVENS GEORGE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Yeer | If Under 24 Hrs. Birthpieca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1**⊠**M 2□ F 217-16-6404 76 Yrs. **Director** Usuei Residence of Decedent with the Marylend permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples of the portion of the contraction o 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits N. A Yes 2□No BALTO **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4.5 1403 21202 RNTRAL . Wes Decadent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritei Status Never Married 2 Merried altimore, Maryland 21215-0020 1□ Yes 2 No Specify: BLACK à 3 □ Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MANDY MAN 18. Mother's Neme (First, Middle, Maiden Si 17. Fether's Neme (First, Middle, Last)). Stevens MASCL Ge0148 19e. informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PASAdena Drive) all ahussee 32.32311 HOLMAN 20b. Place of Disposition (Name of cemetery, cremetory or other place) SeLIN A 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State ZION Cem. 161 Md LANGSdow Ne 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee 22. Neme end Address of Fecility 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enfer the mode of dying, such as cardiac or respiratory errest, shock of heart tailure. List only one cause on each line. Approximeje Intervel Bet Onset end Death **Physician** /Medical immediete Ceuse (Finel disease or condition resulting in death) SEPSIS 2 0445 Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be a secuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest attending physician and for usa as the bural-tran Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown INSURVICIENCY ρ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed is certificate has director, page 2: 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) To Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpetient 3□ DOA this funaral 27. Manner of Deeth Certification: 28c. injury et Work? 28d. Describe how injury occurred After Natural 2 Accident or Attanding 5 Pending investigation n 24 hours after death.

The Funeral Director: After pletely filled in by the fun 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and menner es stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) RES-000 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DOCTOR'S DARICE, JOHNS HOPKINS HOSP. TOWER 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



Division of Vital Records, P.O. Box 68760 Schuette, Corinne

cartificate be executed deeth.

Physician

/Medical

Director

Funeral

2

Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 7. Depertment of Health and Mentel Hygiena. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Madiconce.

Physician /Medical

Examiner

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ed by the all datached fo

ate has been signed by page 2 should be datac

certificate has been

After this funeral Examiner

Physician/Medical

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Completed

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2

Certification:

Medical

3 Suicide

29a. Certifies

4 Homicide

with the Meryland

death

filed within 72 hours after

Saltimore, Maryland 21215-0020

To the Hospital or Attendir within 24 hours aftar deeth.

To the Funeral Director: At completely filled in by the fu

State Registrar

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartitier

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number D 36940

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28, 1999 March

Fallston General Hospital

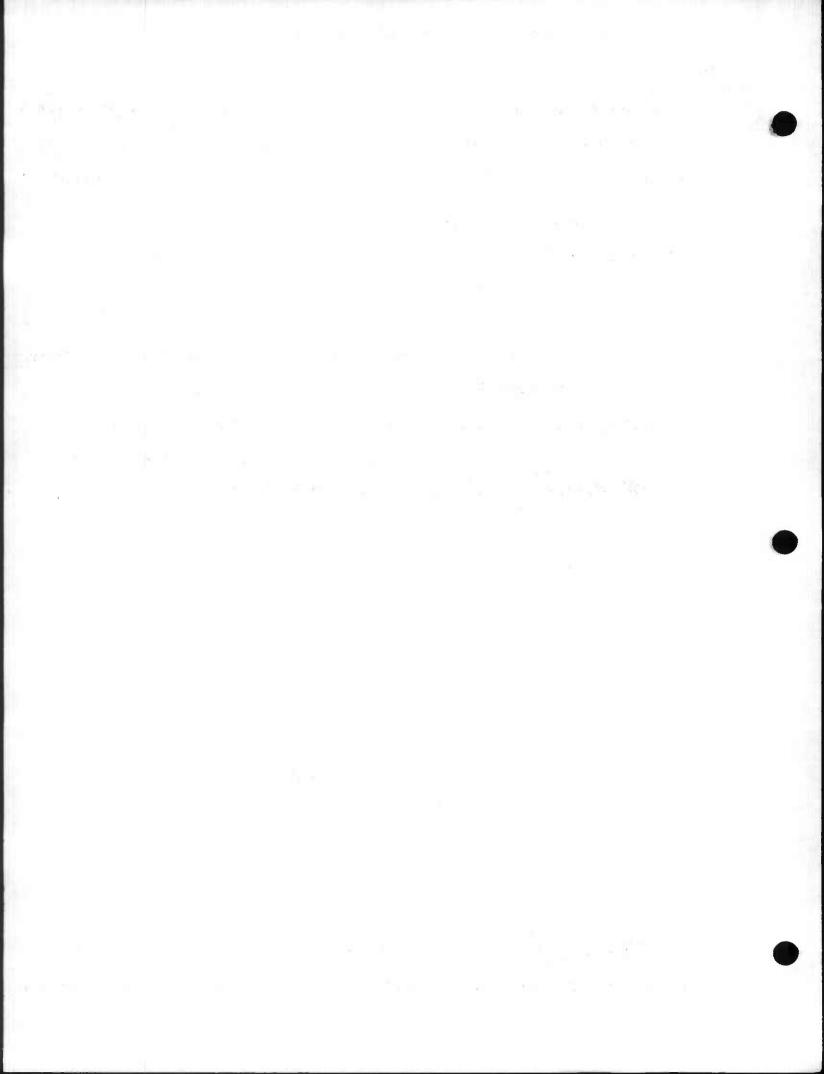
21047

David C. Brick, m.D. 31. Date tiled (Month, Day, Year) 32. Registrar's Signature 1999

APR

6 Could not be determined

200 milton Avenue Fallston Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea Robert T. Shaffer, Sr. 7.30 AM March 24. 1999 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 13827 Bottom Road Hydes Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Yrs. 232-03-0819 85 Mar. 17, 1914 Manheim, W. VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13827 Bottom Road 21082 U.S.A. 11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 N Widowed 4 □ Divorced Specify: White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 yrs. n/a Steelworker Bethlehem Steel 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy E. Shaffer Icy McVicker 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Robert T. Shaffer, Jr. (Son) 13827 Bottom Road Hydes, Maryland 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Locetion - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens 3/27/99 BelAir, Maryland 21014 21. Signature of Funeral Service Licens 22. Name end Address of Facility E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 acoa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List phy one ceuse on each line. Immediate Cause (Final disease or condition rasulting in death) ISCHEMIC HEART DIFFASE YEARS Due to (or as e consequence of): Saquentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NONE 24b. Were autopsy findings 24a. Was an autopsy eveileble prior to completion of ceuse of daath? performed?

Physician /Medical Examiner

The lew requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

10a. State

Funeral

Director

"netural", or items 23a

Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If item 27 is marked other than "netur Lry or other traumatic event, the Medical.

the Maryland to or 28a-f show

filed within 72 hours after death with

21215-0020

Baltimore, Maryland

burief-transi physician Physician/Medicai signed by the ettending be detached for use by Completed has certificete

al or Attending Physician: Ts efter death.
Il Director: After this certificet ed in by the funeral director, pa Be Certification: To To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

2/1 No 1 ☐ Yes 2 PNo 1 🗆 Yes

25. Was case referred to madical examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA 1 Yas 2 PNo Othar: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29b. Signet re end title of certifier

helianden us

29c. License number 29d. Date signed (Month. Day, Year)

30. Name and address of parson who completed cause of death (Itam 23a) (Type, Print)

5601 LOCH RAVEN BLUD \$203 RICHARDEN M.P. 31. Date filad (Month, Day, Yaar)

Registrar

Medical



DHMH 16 Rev 6/95

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 430 %. 4a Facility Name (If not institution, give street and number) 99 29 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner 13 or / Shape Paryland Cil- Birthplace (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Hours Min Yrs 05-16-16 SC 251-16-4358 82 Director Usual Rasidenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 1304 Edison Highway Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 72 hours after p☐ Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16h Kind of Business/Industry American filed within Elamantary/Secondary (0-12) Collaga (1-4or 5+) Sugar Refinery 8th Grade NA Laborer permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if I feen 27 is marked othe
any injury or other traumatic event.
Dates. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Surname) Trapp Ellison Roxanne Howard 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 1304 Edison Highway Baltimore, MD. 21213 Trapp Ruth 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State MD 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 04-02-99 Owings Mills, 22. Name and Address of Facility Baltimore, Maryland 21202 Signature of Funeral Servica Licansee WM.C. March FH 1101 E. North Avenue Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 days Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the bunal-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of) Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 ☐ Yes 2 No 3 Probably 4 Unknown by Division of Vital Records, The law requires 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? been s completion of cause of death? page 2 Aftar this cartificata has A No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Restdence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA s after dea. 27. Manner of Daath 1 (Natural 2 Accident Certification: 28c. Injury at Work? 28d. Describe how Injury occurred Attending 5 Panding investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 6 Could not be datamined 3 ☐ SuicIde 28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicida 0 To the Hospital within 24 hours a To the Funeral C 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai (Check only one) 29b, Signature and title of cartifier 29c. License numbe 29d. Date signed (Month, Dey, Year)

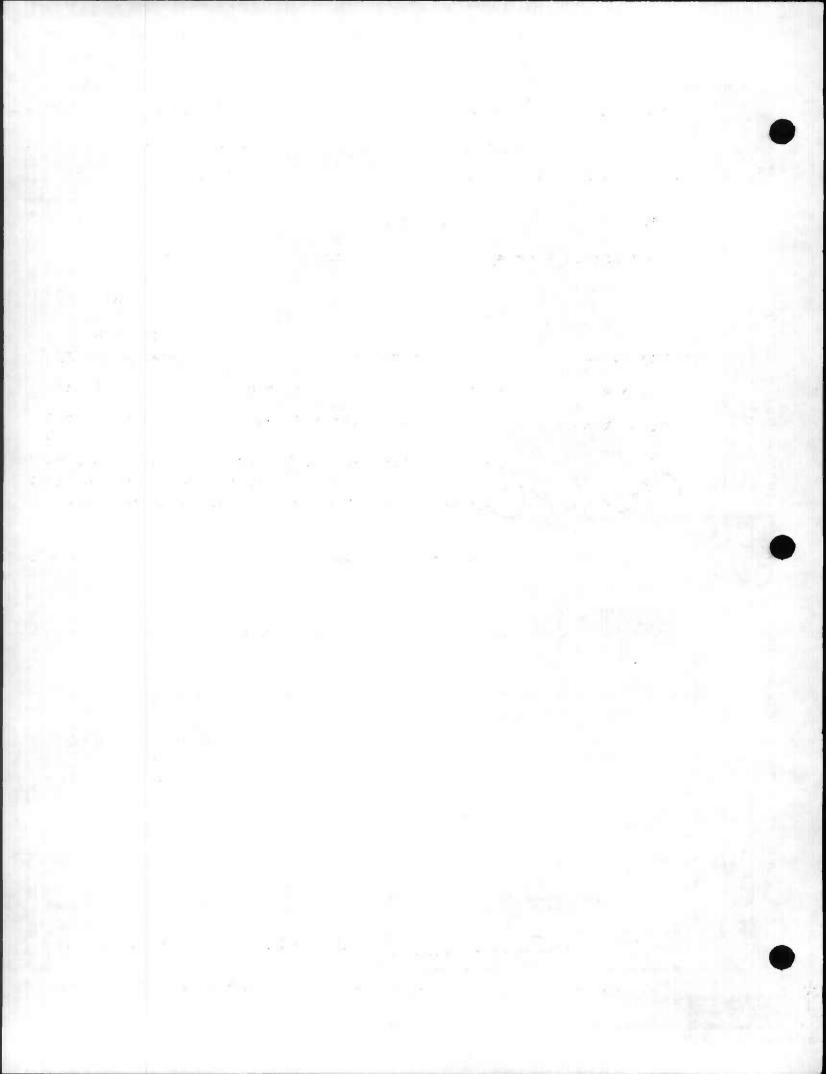
State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 16 Extern 5.

Baltime, MI)



ORIGINAL

THE R P. LEWIS CO., LANSING, MICH.

State Registrar MARGAMAS

31. Data filed (Month, Day, Yaar)

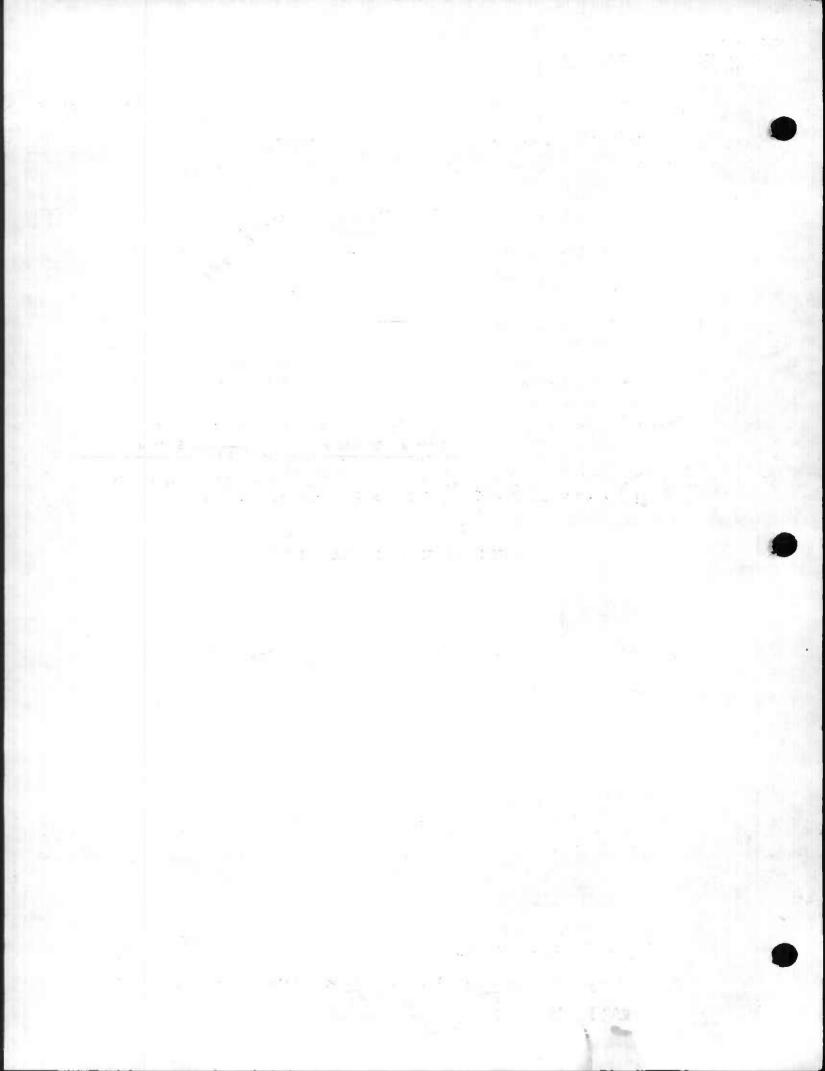
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MAR 3 1 1999

My ward.

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Wooden 29 99 mary /Medical 4a Fecility Nama (If not institution, piva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Blatimore
If Under 24 Hrs. 8. Date
Hours Min. (Mont BonSecour Hospital 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foraign Country) 6 Sex **Funeral** 1□M 2XF Months Deys MD 213-14-0350 Yrs. 80 Director 07-02-18 Usual Residence of Decedent the Marylend 10c City Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, me Medical Examinar main to notified at MD 1X Yes 2 □ No NA Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 11 West 20th Street 21218 USA Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White atc. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0020 f Yes Give 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates Black Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7: nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Housewife in home 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event page. 17. Fether's Name (First, Middla, Last) Charles Johnson Annie Cottman 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Howard Holt 5565 Whitby Road Baltimore, Maryland 21206 of Disposition (Name of Date 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Kings Mem. PK. Cem. 04-02-99 ■ Donetion 5 ☐ Other (Specify) Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 eure of Funeral Service License 21. Sign WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate tritervet Between Onsat and Death Physician /Medical Immediete Ceuse (Final CARDIO PULMONARY disease or condition resulting in deeth) **Examiner** OCARALAL INF Examiner The law requires that the death certificate be executed attending physician end for use es the bunal-tran Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Records, P.O. Box 68760 Physician/Medical VASCULAR DISCASE ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilebla prior fo complation of ceusa of deeth? Completed 24e. Wes en eutopsy performed? hes 16 2 certificate her 1 Vec 2 No 1 Type 2 No Division of Vital lal or Attending Physician: Tr is efter death. al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Reeldence 6 Other (Specify) 2 1 Yes 2⊠ No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 SNaturel 5 Pending investigation Injun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not ba 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide in 24 hour.
the Funeral Direction Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner es stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edicai

State Registrar

APR 1 1999

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

ONYCHAKA

29b. Signeture and title of certifier -

VICTOR

31. Date filed (Month, Day, Year)

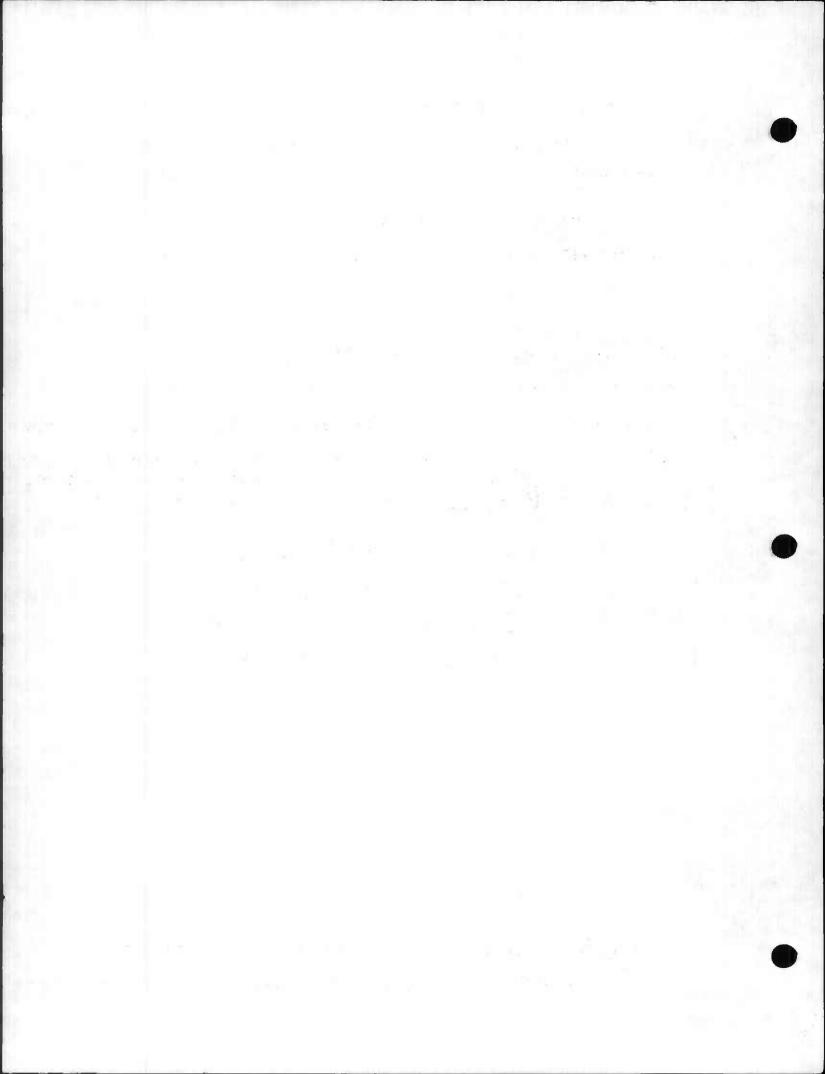


MA

2000 WEST BALTIMORE STREET BALTIMORE MARYLAND

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Yeer **Physician** CARROLL SHIELDS WATTS 27. 1999 MARCH 7:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nema (If not institution, giva street end number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F 215-24-4360 MARYLAND Director 12/13/12 Usuel Residence of Decedent with the Merylend 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f short ner must be notified at 1 ☐ Yes 2 XNo TOWSON BALTIMORE Directo MD 10e. Street and Number 10f. Zip Code 10g. Cifizen of Whet Country? USA 302 E. JOPPA ROAD APT. 805 21286 Funeral deeth Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, r than "natural", or item the Medical Examiner Black, White, etc. Pages 1 end 2 should be filled within 72 hours efter nent of Health and Mentel Hygiene. not if item 27 le marked other than "natural", or ite 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Maryland 21215-0020 If Yes, Give Yeer or Detes 1 ☐ Yes 2 ▼ No Specify: Specify: þ WHITE 3X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) STATE COLLEGE 1 YEAR SUPERVISOR TELECOMMUNICATION 17. Father's Neme (First. Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be ESTELLA BOSLEY WALTER S. SHIELDS P 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 8423 WILLOW OAK ROAD BALTIMORE, MD 21234 SON other EDWARD V. WATTS, JR. altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Locetion - City or Town, Stete 20e. Method of Disposition Burlel 2 Cremetion 3 Removel from State 0 permit. Page Department of Important: If any Injury or pace. 4 ☐ Donetion /5 ☐ Other (Spacify) 4/1/99 TOWSON, MD PROSPECT HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Nama and Address of Fecility THE JOHNSON FUNERAL HOME, P.A. Part Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, procedure. List only one certified in the caused the deeth. 21286 TOWSON, MD Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel RESPIRATORY FAILURE disaase or condition resulting in deeth) Examiner Due to (or es e consequence ol): Examiner POSSIBLE CONGESTIVE HEART FAILURE physician end the burief-transit certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence ol): Box 68760 Physician/Medical Dua to (or as a consequance of): 98 esn ō 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o the deteched signed by t d be detect 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, à 24b. Were autopsy findings eveilable prior to Completed 24a. Wes en eutopsy peen completion of ceuse of deeth? pege 2 hes 2 ANO 1 Yes 1 ☐ Yes 2 No certificete Division of Vital or Attending Physician: director 25. Wes cese referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 12 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 28c. Injury et Work? 27. Menner of Deeth 28b. Tima of 28d. Describe how Injury occurred Certification: After 1 Neturel Injury 5 Pending efter death. Director: Aft 1 Yes 2 No invastigetion 2 Accident 6 Could not be determined 3 Suicide 28a, Plece of Injury - At home, ferm, straet, fectory, office building, atc. (Spacify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours e Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to tha cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and mannar stated. To the within 2 29b. Signeture and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) Ď

Registrar

State

31. Dete filed (Month, Dey, Year) APR

30. Name and eddress of person who completed clause of deeth (Item 23e) (Type, Print)

SAMER SAIEDY, .. M. D., 32. Registrar's Signetura

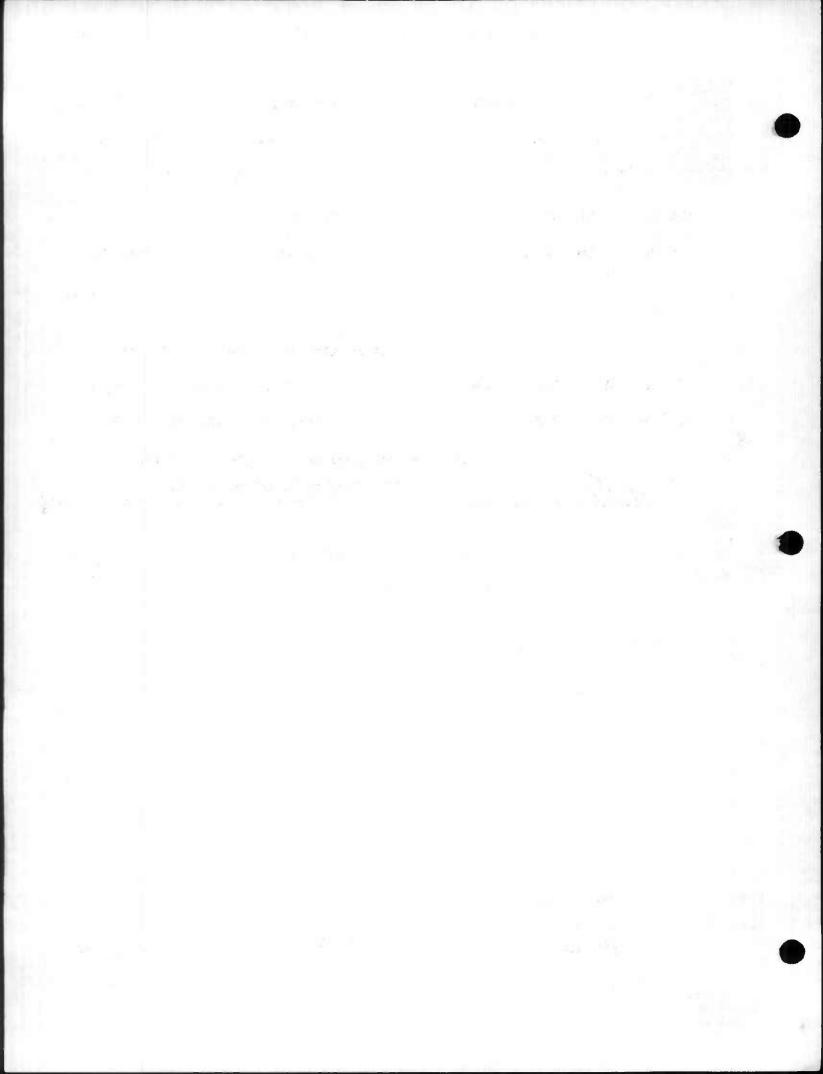
7600 OSLER DR. TOWSON, MARYLAND

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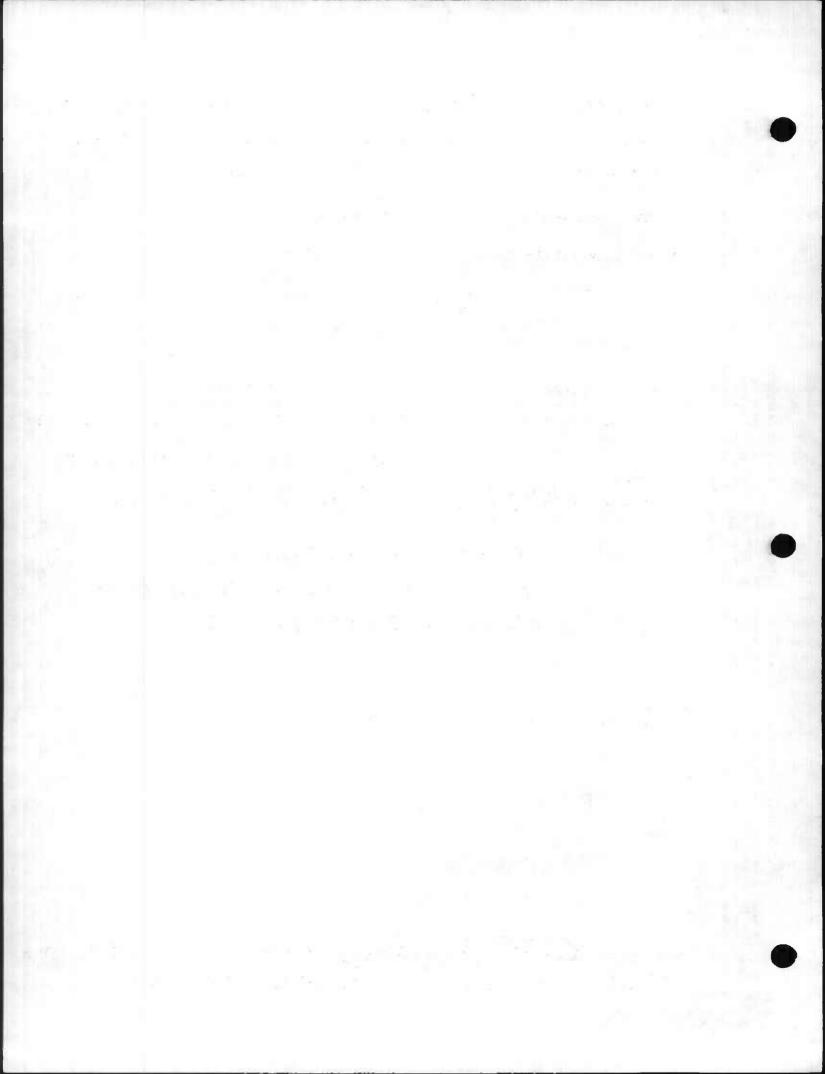
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State 31. Dete filed (Month, Day, Year) 82. Registrer's Signeture	2/09		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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To the Hospital or Attending I within 24 hours either death. To the Funeral Director: After completely filled in by the funeral		29a. Cartifiar	1☐ Certifying P	hysician: To th	a bast of m	v knowladna	daath d	occurred at th	ne tim	ne dete an	d place	and due to the	causel	s) and ma	nner as sta	sted	
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()		30. Nama and addr	rass of person who	completed cau	use of death	(Item 23a) (Type, P.	rint) / / /	1	Yan	1/0	+411	1/1	2			.,
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Physician 12:20 Am DSEPH WYCHRY MARCH 1999 29 /Medical 4b. City. Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Franklin Woods Rehabilitation Center Rosedale Baltimore 6. Sex 1X M 2□ F 7. Age (In yrs. lest birthday) If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days Hours 25-28-3166 Director Poland Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at MD Baltimore Rosedale 1 ☐ Yes ※☐ No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 8213 Old Philadelphia Rd. 21237 USA Funeral deeth Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stafus Bleck, White, etc. permit. Peges t and 2 should be filed within 72 hours after to Department of Haelth end Mentel Hygiena. Inportant: If them 27 is marked other than "natural", or her any Injury or other traumatic event 1 Never Married Merried 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Machinist Steel Tin Co. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Michael Wychryst Mary Popowicz 19a. Informent's Name/Relationship (Type, Print) Angela A. Wychryst / wife 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code, 8213 Old Philadelphia Rd. Rosedale, MD 212 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Sacred Heart of Jesus 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriai 2 Cremetion 3 Removal from Stale 3-31-99 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the caused the death. Þ Approximate Interval Between Onset and Death Physician Encer with Metastasii /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner certificata be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieled events resulting In death) Lest pue Due to (or es e consequence of): bunal-tran Box 68760. physician Physician/Medical the Due to (or es e consequence of) 98 9SN Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menger of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending investigation efter deeth. 2 No 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted. edical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to fine cause(s) and menner stated. (Check only one) 29b. Signature end fitle of cartifier 29c. License number 29d. Date signed (Monthy Dey, Year) 00

State Registrar

JANAI 31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who

6730

HOLABIRD AVE. 32. Registrer's Signeture

ploted muse of deeth (Item 23e) (Type, Print)

BALTIMORE, MD

21332

If Under 1 Year

10f. Zip Code

Months

Days

21226

7. Age (In yrs. last birthday)

10c. City. Town or Location

Baltimore

48

State of Maryland / Department of Health and Mental Hygiene

O Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:45P.m. MGRCH Joseph C. Wolf Jr. 30 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Glen Burnie

8. Date of Birth (Month, Day, Year)

June 2, 1950

If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.)

Anne Arundel

14. Race - American Indian,

Black, White, etc.

10a. Citizen of What Country?

U.S.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

Funeral Director

Physician

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Maniel Hyglens. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show eny injury or other traumatic event, the Medical Exercises must be notified at each.

Maryland 21215-0020

Baitimore,

Box 68760.

P.O.

Records.

of Vital

Division

JOSEPH

Physician /Medical Examiner

signed by the e pege 2 s or Attending Physicien: this funeral After

A Hospital or 24 hours of Funeral Di-letsly IIIled In To the Hosp within 24 ho To the Fune completely I

Physician/Medical Examiner ģ Completed Be Certification: To deeth. ofter deeth Director: 3 edical

217 54 0879 **Usual Residence of Decedent** 10s. State 10b. County Maryland Anne Arundel Director 10e. Street and Number 932 Chestnut Woods Court Funeral 11. Marital Status 1 Never Married 2 Married Š 3 ☐ Widowed 4 ☑Divorced Completed Elementary/Secondary (0-12) 12th 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. nth) Last resulting in d 25. Was case referred to medical examiner? 1 Yes 2 No

North Arundel Hospital

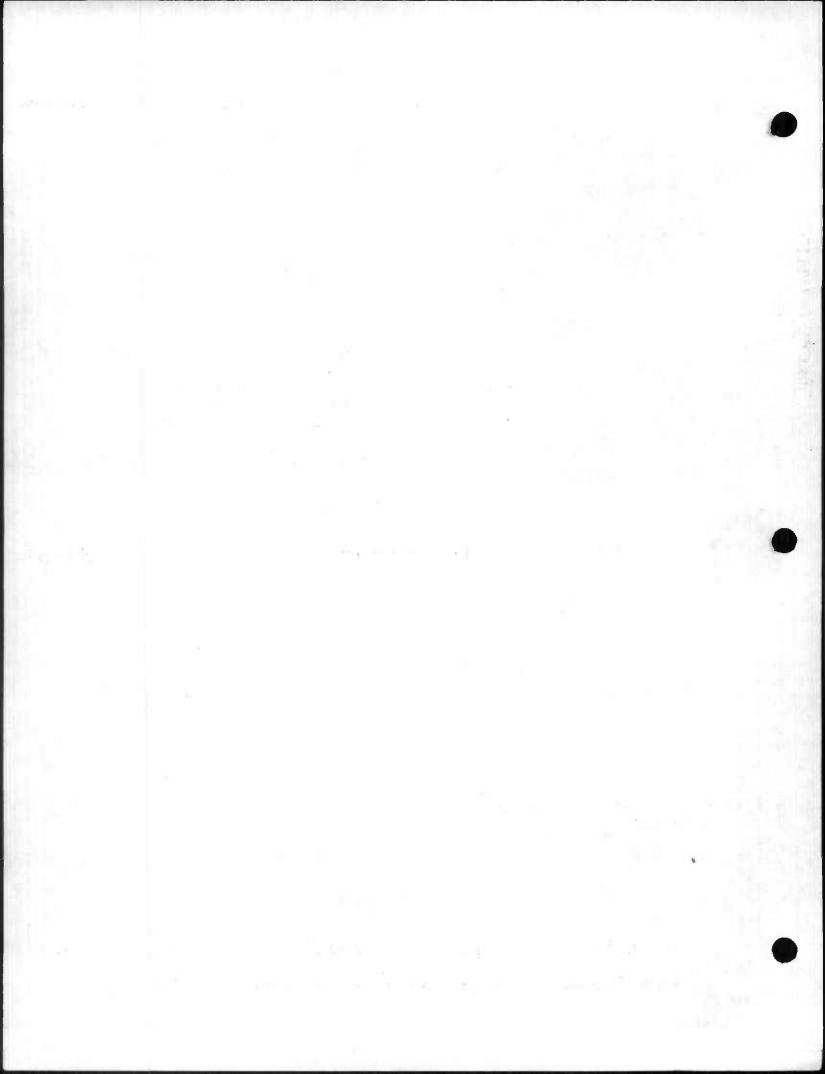
1⊠M 2□ F

5. Social Security Number

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Dispatcher Blue Print 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph C. Wolf Sr. Ethel Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Ernest / sister 406 Prospect Street Luverne, Iowa 50560 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/3/99 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway 23a. 1-1001 K1tCn1e Highway Baltim.
23a. 1-1001 Enter the decade of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a hook, or heart failure. Life only one cause on each line. granuousk Baltimore, Md. 21225 Approximate Interval Between Onset and Death PNEUMONIA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 ☐ Yes 212 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred **W**Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March mp. 30 1999. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gyoken Okethani
31. Dete filed (Month, Day, Year) Has Fal & 32. Registrar's Signature Down, Glen Busnie. mp. 21061. 301

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MARCH :47 p.m MELAT YACOB 1999 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A BALTIMORE HOPKINS CITY JOHNS HOSPITAL Dete of Birth (Month, Day, Year) 1/13/99 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 2 1□ M 213 F Yrs. MARYLAND 16 Usual Residence of Decadent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 17 TREEWAY COURT USA APT. 3C 21286 14. Race - American Indian, 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ETHIOPIAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) YESHIMEBET SHIFERAW YACOB ASTATKE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 TREEWAY COURT APT. 3C TOWSON, MD YACOB ASTATKE 21286 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State Burial /2 Cremation 3 Removel from State

3/31/99 COCKEYSVILLE, MD

March 29, 1999

Physiciar /Medica Examine

Physician

/Medical

Examiner

N/A

10a State

MD

N/A

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licanse

Director

Funeral

by

Completed

Be

10

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examinar maint be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter c Department of Heelth end Mental Hygiena. Important: If Item 27 is marked other than "naturel", or iten any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

with the Marylenc

should be date To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

23a/Pant Enter the disease, or or or heart feilure. List an	mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erre	St,	Approximate Intervel Between Onset and Death		
Immediate Cause (Final disease or condition	SEPS15	48 havs			
resulting in death)	Due to (or es a consequence of):				
	PNEUMONIA		10 days		
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Cause (Diseese or injury that initieted events resulting in death) Last	c				
			ntribute to the cause of death?		
cardiomyopat	1 Ye NEART disease 24e. Wes an perform		24b. Were autopsy findings evaileble prior to completion of cause of death?		
	1 □ Ye	s 2NNo	1 □ Yes 25 No		
25. Was case referred to medical examiner?	26. Place of Death (Check only one)			
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residen	nca 6 Oth	ner (Specify)		
27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigat	(Month, Day Year) Injury Work? ion M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not determine	286. Pieca of injury - At nome, farm, street, factory, offica 201, Location (3)	28f. Location (Street end Number or Rural Route Number, City or Town, State)			
29a. Certifier Certifying (Check only one) Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ce aminer: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, da and manner stated.	use(s) and me te end place,	enner es stated. end due to the cause(s)		
29b. Signeture and title of certifier	29c. License number 29	d. Date signe	d (Month, Day, Year)		

deeth (Item 23a) (Type, Print)

Johns Hopkins Hospital, Baltimore, MD

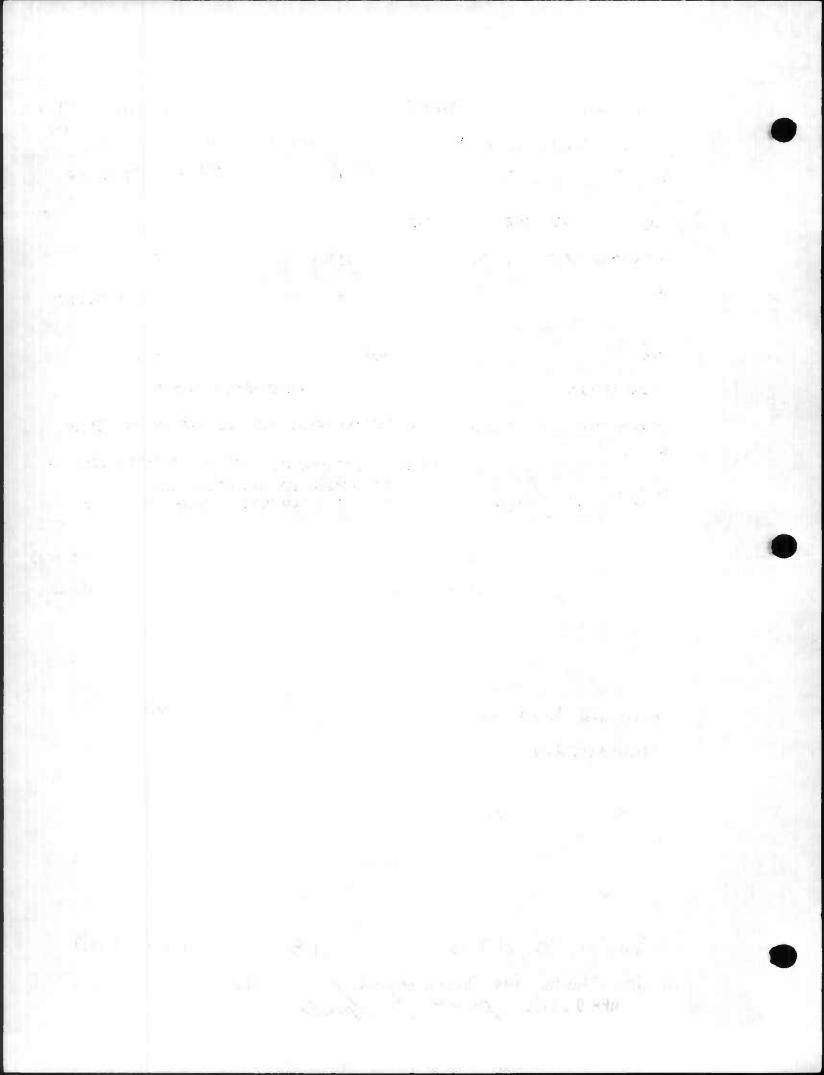
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DULANEY VALLEY MEM. GAR.

22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A.

State Registrar



Funeral

Director

x 28a-f show

rai', or items 23a or

d 2 should be filed within 72 hours effer th and Mental Hygiene.
7 ie marked other than "natural", or itei treumatic event, tre Mesical Examinel

permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other treumatic event, once.

Physician

The law requires that the death certificete be axecuted

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

Hospital

/Medical Examiner

physician end the buriel-transit

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month MARCH **Physician** 17, 1999 1:33 PM. Dorothy Hart Adkins /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner North East

If Under 24 Hrs.
Min.

8. Date of Birth
(Month, Dey, Year) RT. 7AREA WELL CAMP RD Cecil 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (Stete or Foreign Country) Deys 1□M 2₺F Months Yrs. 63 215-34-6808 February 27, 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XX Yes 2 □ No Directo Maryland Cecil Charlestown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 253 Black Avenue 21914 Funerai United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marltai Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 10 Her own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Doris Nesbitt Wilber Calvert 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Harris / Daughter 79 Plum Creek Road, North East, MD 21901

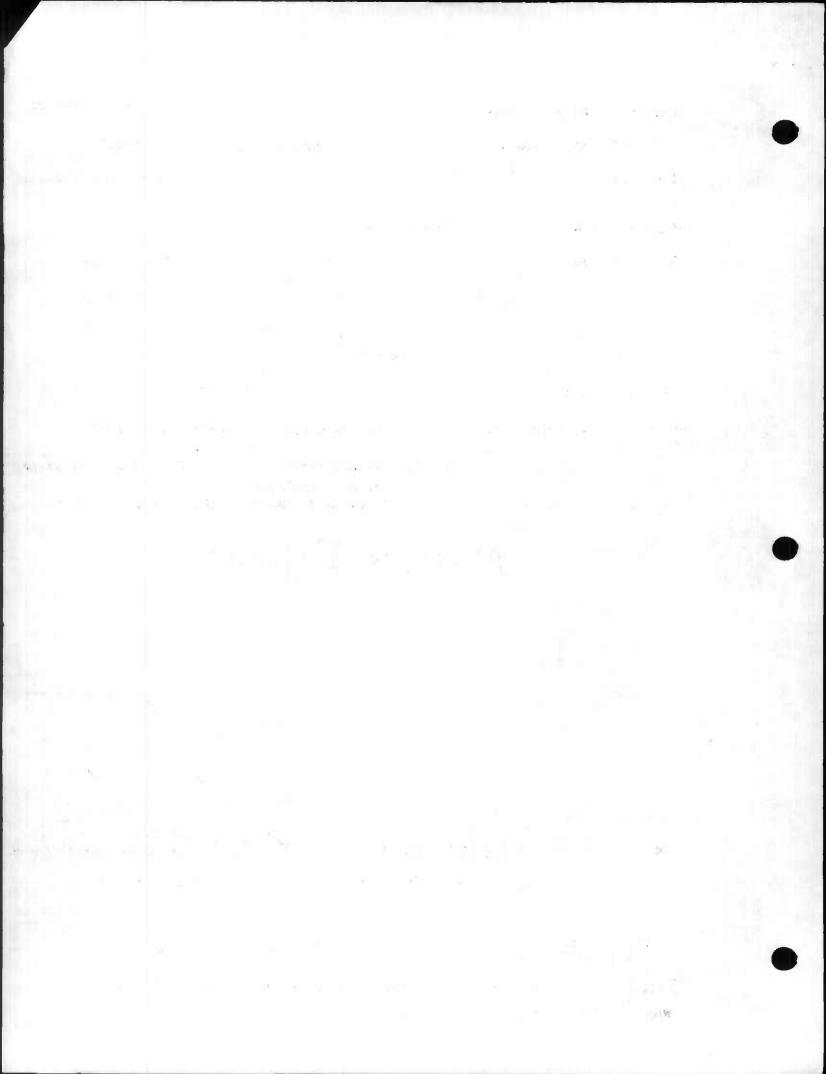
e of Disposition (Neme of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other placa) March 20 1 Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Charlestown Cemetery 1999 Charlestown, Maryland 21. Signeture of Funeral Service Libertus 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieled events resulting in deeth) Lest Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the ceuse of deeth? Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 1 Yes 1 Yes 2□ No 25. Wes case referred to medical examiner? Be 26. Piace of Death (Check only one) AT Other: 4 Nursing Home 5 Residence 5 Other (Specify) Hospital: 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred
Driver of motor
Co ilicles with SCENE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: renicle 1 Netural 5 Pending 3 177 9 132 M 10 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No Investigation another yehiod 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Lecil County Rt. Street 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menher es steted. 29a. Certifie edicai Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. MARCH 18, 1999 30. Name and address of person who completed cause of death (item 23a) (Type, Print) estaner Jo 111 Penn Street, Baltimore, Maryland 21201

State Registrar

10

Date filed (Month, Dey, Ye MAR 1 9 1999

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Hygiene 99 1052

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Mar 16, Day Year **Physician** 20:50 pm Alma Lee Adams /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Allegany Cumberland If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Month Day Year) 1930 9. Birthplaca (State or Foreign **Funeral** 1 M 2 F Months 215-26-6202 68 Davs Hours Director Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglane. Important: If them 27 is marked other than "neture!", or thems 23e or 28e-f show eny Injury or other treumetic avant 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits W/7 Mineral Fort Ashby 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 316 26719 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes Z☐ No Specify: 11 Marital Status 14. Baca - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: by 3 Widowed 4 Divorced white Completed 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Goilege (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hetrick Hiner Mary E. (Pittman) 2 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) George K. Adams-husband Box 316 Fort Ashby WV 26719 20b. Place of Disposition (Name of cometery, crematory or other place)
Mt. Herman Cemetery 20a. Method of Disposition
1 Burlal 2 Cremation 3 Removal from State 20c. Location - City or Town, State 03/19 Cumberland MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral SafVice Licenses 22. Name and Address of Fautheral Home, P.A. Cumberland MD 21502 23a. Part1. Enter the disease, or complifations that caused the death. shock, or heart feilure. List only on cause on each line. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Approximete** Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequence of): attanding p usa MARCH 1711899 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? 2000 been signed by should be datac 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? paga 2 has cartificata 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of 1 Matural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the global 29d. Date signed (Month, Day, Year) 29c. License number D22181 3 ompleted ceuse of death (Item 23a) (Type, Print)
r Bishop Walsh Drive Cumberland MD 21502 Dr. Gary Wagoner hu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

SERVICE STATE

Registrar

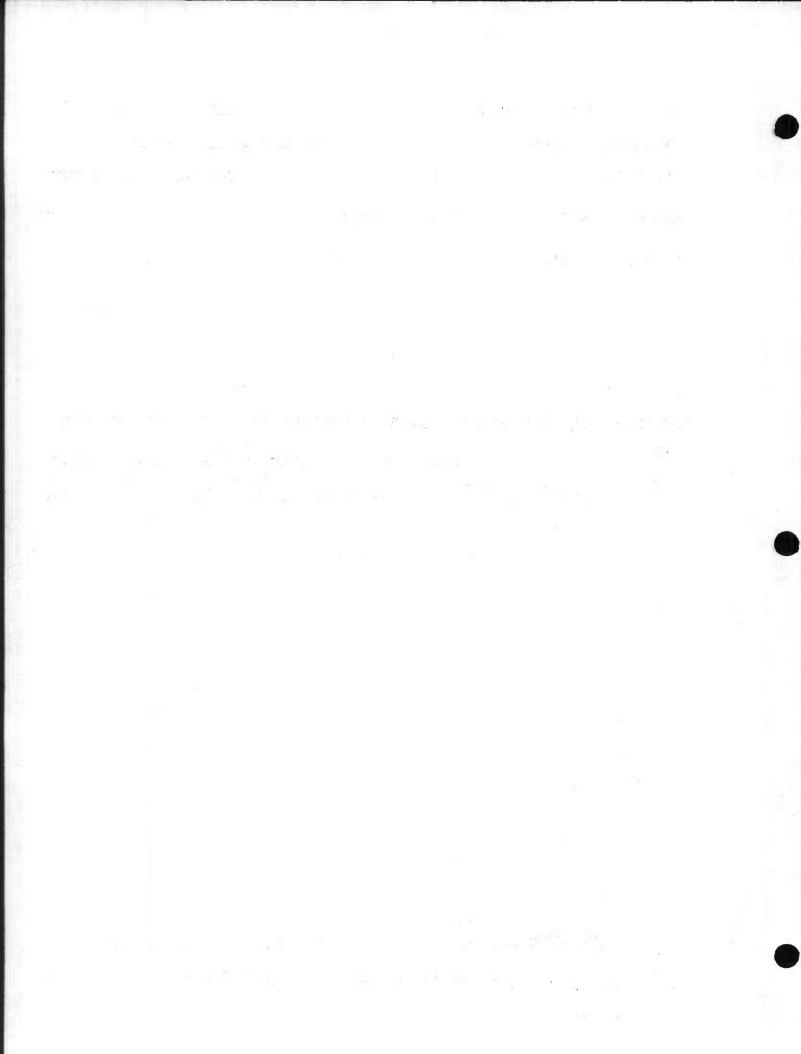
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	Funeral		PENNINSULA REGIO 5. Social Security Number 6. S	Sex 7. Age ((In yrs. last bir	rthday)	If Under 1 Year Months Days		s. 8. Date of Bi	wico		niace (State or i	Foreign	
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	the Marylar r 28a-f show	tor	MD Wicomi	CO	Sa	alisk	111777					1 ☐ Yes a	XNo	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?		
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三 AdK/ 21215-0020	72 hours after death v "naturel", or Itams 23s	Ped	15. Decedent's Ed	ducation	16a.	. Deceder	nt's Usual Occu	pation		16b. Kind of B				
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and	be fill d off	Be	17. Fether's Name (First, Middle, Last,					18. Mother's Na	ame (First, Middle	, Maiden Sumar	ne)			
20 2	d Mar marke	2	Marion S. 19a. Informent's Name/Relationship (Pryor		Mailing	Address (Chas	Florence	CE Ru <i>ral Rou</i> te Numb		ousto			
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300	Page nant of iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State		-	Memoria	•	3/20/99	Salisbu	rv. M	arvlan	d	
Soltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Monce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
	80 5 8 8		Holloway Funeral Home, Professional Associat											
			23a/Part 1. Enter the disease, or complications that cere divided each. Do not enter the mode of dying, such as Cardiac of respiratory arrest, Approximete interval Between Consett and Be											
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	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2	edical	29a. Certifier t⊠ Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best of n niner: On the basis of ex	ramination en	, death o	ccurred et the ti	me, date and piac opinion, death occ	ce, end due to the curred at the time,	cause(s) end me date and place,	enner as st and due to	ated. the cause(s)		
	o the ithin o	Mec	29b. Signeture and title of certifier	and manner stated	d.			9c. License number 29d. Date signed (N						
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			30. Name and address of person who	completed cause of deat	th (item 23a) (Type. Pri					7.,,	•		
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DHMH 16 Rev 6/95

				to or iviaryland	Certificate of			Reg. No.	99	1058	25
	Physici	an	1. Decedent's Neme (First, Middle, Last)				2. Dete of De Month	eth Dey	Yeer	3. Time of D	Death
	/Medic		ESTER CARRAO	ALONZO			MARCH	16	1999	545A	m.
	Examin		4e. Fecility Neme (If not Institution, give street en	nd n <i>umber</i>)		4b. City, Town, or	Location of Deeth	4c. Co	ounty of Deeth		
			430 RIVERSIDE DRIVE			PRINCE FI	REDERICK	CAL	VERT		
	Funeral		5. Sociel Security Number 6. Sex	7. Age (In yrs. la	ist birthday) If Under 1 Ye Months De	ar If Under 24 Hrs			- T	piece (Stete or antry)	Foreign
	Director		214-04-9425	₫F 81	Yrs. Months De	ys rious Mill.			17 PHI	LIPPINE	S
	g		Usual Residence of Decedent							and after the public and a final to	
	how		10e. Stete 10b. County		, Town or Location					10d. Inside City	Limits
	n 72 hours after death with the Maryland *natural", or items 23a or 28e-f show polical Examinet must be nothed at	Director	MARYLAND CALVERT	PRIN	NCE FREDERICK					1 ☐ Yes 2	20XNo
	7 28	ie.	10e. Street end Number		10f. Zip Code	9		10g. Citize	n of Whet Cou	ntry?	
	3a o		430 RIVERSIDE DRIVE		20678			TT	S. A.		
	Jeath 2	Funeral	11. Maritel Stetus 12. Wes	Decedent Ever in U,S		of Hispenic Origin? (S uben, Mexican, Puerl	specify Yes or No		Rece - Ameri	can Indien,	
	the r	Ē	Arm	ed Forces? Yes 2√2 No			to Ricen, etc.)		Bleck, White,	, etc.	
22	17. a	by	If Ye	s, Give Tror Detes:	1 ☐ Yes 2X N	lo Specify:		S	pecify:	IPINO	
21215-0020	2 hou	8	15. Decedent's Education		16e. Decedent's Usuel Occ	cupetion	1	16b. Kind	of Business/Ir		
15	- 0 30	olet	(Specify only highest grade compl		(Give kind of work do	ne during most of wor ired)	rking			,	
212	d within jiena. r than	Completed	The state of the s	ege (1-4or 5+) 1	TEACHER.			SCHO	OT		
D	真花草		17. Fether's Neme (First, Middle, Last)	<u> </u>	TEACHER.	18. Mother's Nar	me (First, Middle,				
a	T T T T T	o Be	FELIX CARRAO			ANIDDE	A DAGUNA				
Maryiand	d 2 should b th end Mente 7 is merked traumetic a	P	19e. Informent's Neme/Reletionship (Type, Prin	1)	19b. Mailing Address (Stre				Town State 7	n Code)	
M	d 2 s h er r is trau		RUBY C. ALONZO, M.D. /D.		430 RIVERSID						
	E P E E		20e. Method of Disposition		ace of Disposition (Name of		- 1		tion - City or T		
Baltimore,	8 5 5 0		MBurial 2 Cremetion 3 Removel	from Stete ce	metery, crematory or other p	olace)	MARCH				
Ħ	permit. Page Department Important: If any injury or once.		4 Donetion 5 Other (Specify)	SOUT	THERN MEMORIA					MARYLAN	
3al	Depariment in portion in procession in proce		21. Signature of Funerel Service Licensee	0-		dress of Fecility LE					
	40 = # O		Joseph Dant	Lista	8125 SOUT	HERN MD B	LVD. OWI	NGS,	MARYLA	ND 2073	6
			23a Part Enter the disease, or complications shock or heert feilure. List only one cause	that caused the deeth.	Do not enter the mode of o	tying, such es cerdie	c or respiratory e	rrest,		Approximete Interval Between	een.
V	Physician									Onset and De	eath
а	/Medical		Immediete Ceuse (Finel disease or condition	mul	tiple strol	252					
	Examiner		resulting in deeth)		as e consequence of):						
-	D #	Examiner									
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0	an a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						i		
68760,	nysic he bi	edicai	Cause (Diseese or Injury that Initiated events resulting In deeth) Lest	Due to (or	es e consequence of):						
	= 00		Todaking in death, Lest						1		
Box	death certing e attending od for use e	Physician/M	d								
	the atte	Sich	Pert II. Other significant conditions contributing	to death but not resul	ting in the underlying cause	given in Pert I.	23b. Dld 1	tobacco ua	e contribute t	o the cause of	death?
P.0	± > 3	, L	,				10	Yas 2	M6 3∏Pro	bably 4 U	nknown
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of Vital Records,	v require been sig should b		15 1 04	11.4	1 0			en eutopsy	24b. W	ere autopsy fin	ndings
8	_ 00	Completed	diabetes me	elle Mes y	yese 2		репо	rmed?	C	eilable prior to empletion of cau deeth?	use
Re	0 - 0	E	gostrits?		,		400	res 2			
Ø	delan: The		25. Wes case referred to medical				101		40	☐ Yes 2☐ N	10
5	Physician: this certific ral director,	o Be	exeminer? 1 Yes 2 10 10 Hospitel:	401		Other	eth (Check only o		7		
o	Phys rai di	- To			Proutpatient 3 DOA	4 LI Nursing F	lome 5 Pesto 28d. Describe I			ty)	
on	ding h. After fune	tion	1 Neturel 5 Pending	(Month, Dey Year)	Injury V	Vork? ☐ Yes 2 ☐ No	200. 5000.150		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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Division	i or Attanding P after death. I Director: After t d in by the funera	Certification:	4 ☐ Homicide determined 286.	building, etc. (Specify)	ne, ieim, sileet, iectory, om		City or Tox		Various of Tibi	ar i route reambe	, pr
_	To the Hospital or Attanding Physician: whithin 24 hours after death after this certific to the Funeral Director. After this certific completely filled in by the funeral director,		29a. Certifier 1 Tertifying Physician: T	o the heet of my ke	lades, double consumed of the	time date and direct	nond due to the	001100/-1	d manager at	at at a d	
	Fun Fun	edical	(Check only 2 Medical Examiner: On	o the best of my know the basis of examination menner steted.	on end/or investigation, in m	y opinion, deeth occu	rred et the time,	dete end pl	ece, end due t	to the ceuse(s)	
	To the within 2 To the comple	Me	29b. Signature and title of cartifier	menner steted.	age Tio	ense number		29d Date 4	signed (Month,	Day Voerl	
	6 를 다 일		hantt-	oform		39522		2/	10/69	Juy, rodry	
			- govern	_				71	4/11		
			30. Name and address of person who completed	Frence 7	23a) (Type, Print)	11/2	0625	-/4	AAIQTII	N11 #	noc)
			110 (forsital Rd. 31. Dete filed (Mortith, Dey, Year)			(1/m Z	2011	()	WIND IN	AN FE	HIW)
		te	Si. Date liled (MORIR, DBY, YBBT)	Registrer's Signetu	JI O						_

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle 3. Time of Death ENSON MARC 4b. City Town, or Location of Deeth ility Neme (If not institution trive st 4c. County of Death SALTIMORE TIMORE If Under 1 Year 8. Dete of Birth (Month, Dey, Year) March 27,1937 6. Sax al Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) Deys Months 1 M 2 □ F 131-28-3705 Yrs. 61 New York Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1√2 Yes 2 No Maryland Harford Havre de Grace 10e. Street end Number 10f. Zip Code 10g. Cifizen of Whet Country? 21078 U.S.A. 303 Commerce Street, Apt. No. 1 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Biack, White, etc. 1XXYes 2 □ No If Yes, Give Yeer or Detes:1954-58 1 ☐ Never Married 2 Married 1 Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Eastmen Kodak Elementery/Secondery (0-12) College (1-4or 5+) Rochester, New York Maintenance Twelve Years 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles Benson Eva Holmes 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 303 Commerce Street, Apt. 1, Havre de Grace, Maryland 21078 Sharon Benson (wife) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremetion 3 ☐ Removei from State R.A. Ferris & Co., Inc. 3/22/99 West Chester, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligences Lee A. Patterson & Son Funeral Home . Millerson, Perryville, Maryland 21903-0188 Mula 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final diseese or condition resulting in death) to (or es e consequence of) Due to (or es e consequença of) Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yea 2 No 3 Probably 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy completion of cause of deeth? 2 No Yes 2□ No

Physician /Medical Examiner

burial-transit

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physician g

signed by the at d be datached for

has

this funeral

After

To the Hospital or Attending I within 24 hours aftar death. To the Funeral Director: After

Be

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Certification:

Medical pletaly

Box 68760

P.O.

Records.

Division of Vital

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Physician

' /Medical

Examiner

10e Stete

Funeral

Director

28a-f show

6

items 23a death

"natural", or

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other treumatic event

the Medical Examiner must be notified at

traumatic event.

Director

Funeral

by

Completed

the Maryland

72 hours after

Saltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Physician/Medical by Completed

Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

26. Place of Deeth (Check only one)

25. Was case referred examiner?	d to medicel
27 Manner of Deeth	
Neturel	5 Pendin
2 Accident	investig

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient

2 ER/Outpetient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homiclde

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

MAR 2 2 1999

29c. License number

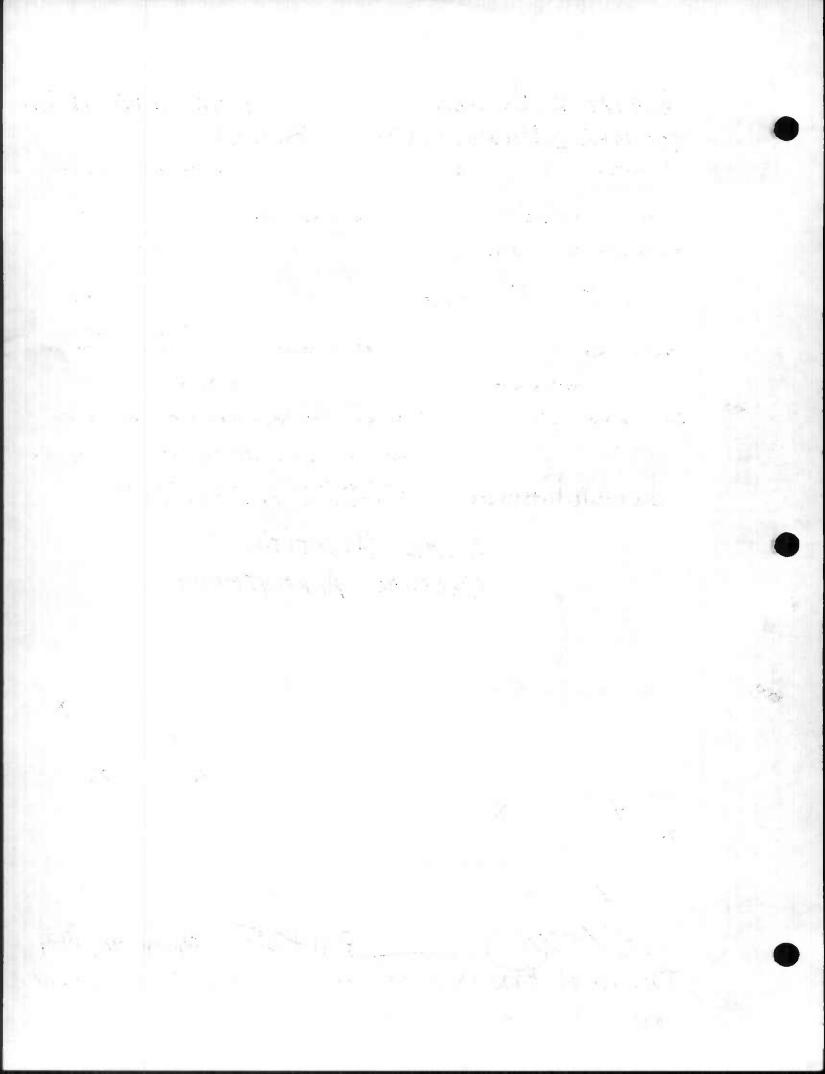
29d. Dete signed (Month, Dey, Year)

e of death (Item 23a) (Type, Print

greeneStreet Balto, MD 21201 10 32. Registrer's Signeture

Registrar

9+11/1



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

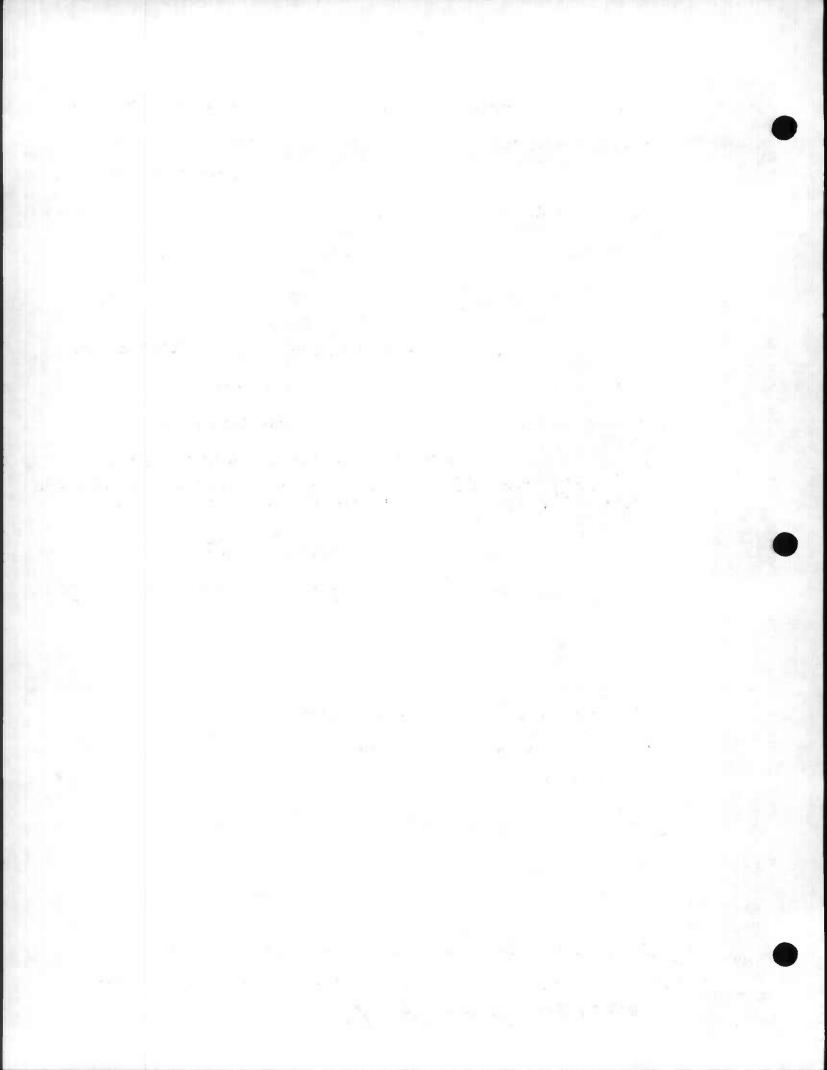
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			1. Decedent's Ner	ne (First, Middle	Lest)					2. Date of D	neg. No.		3. Time of Deeth	
	Physic	ian			tinger Sr.					March	17 Day 199	Voor	:00 p.m.	
1	/Medi		-			er)	4h City Town	or Location of Dee						
A	Exami	ner	4e. Fecility Neme (If not institution, give street end number) Egle Nursing Home							ing	4c. County of Deeth Allegany			
ŀ	Funeral		5. Social Security			Age (In yrs. la	st birthday)	if Under 1 Ye					e (Stete or Foreign	
1	Director		214-01-	6685	1 ⊠ M 2□F	89	Yrs.	Months De	ys Hours M	lin. 8. Date of B (Month, D March		Country)	MD	
	D .		Usual Residence	1						raten	J, 1710		T-III	
	ehow	_	10e. Stete	10b. County Allegar			Town or Loc COning						Inside City Limits	
	Nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours efter death with the Meryland to of Health and Mental Hygiene. If Item 27 is merked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Modical Examinational contribution.	Scto	MD				1 Yes 2 □ No							
		D.	10e. Street end No	е		10g. Citizen of	Whet Country	7						
		rai		son Stre			1	21539			USA			
		Funeral Director	11. Marital Status	ried 2 Marris	12. Wes Decede	95,?	. 13. W	as Decedent of Yes, specify C	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 14. Rai	ce - Americen ck, White, etc.		
)20	irs ef	by F	1 Never Married 2 Married								Specif	_{y:} White	9	
0-0	21215-0020 d within 72 hours ef glena. rr than "natural", or	B		15. Decedent's	s Educetion		16a. Decede	ent's Usuel Oc	cupetion		16b. Kind of B	usiness/Indust	irv	
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pu	tal Hy d oth	Be	17. Fether's Neme		•				18. Mother's N	lame (First, Middl	le, Maiden Sumer	ne)		
yla	Baltimore, Maryland 212: bemit. Pages 1 end 2 should be filed within bepartment of Health and Mantal Hygiene. mportant: If Item 27 is merked other than any injury or other traumetic event, the Mance.	2	Jacob B	ittinger	<u> </u>				Elizab	eth Hoov	er			
Jar			19e. fnforment's N						eet end Number or			de)		
			PAUL D 20e. Method of Dis	Bittinge	er s	son		aptist ition (Neme of	Road, Hai					
יסר	ages or or		1 Burial 2	Cremation :	3 □Removal from Sta		netery, creme	etory or other	olace)	March20	20c. Location - City or Town, Stete			
H	t. Pa			5 Other (Spe		al Park								
Ba	Depariment Department on Institute on Instit		21. Signature of F		nc Kenzi				dress of Fecility I—McKenzie	e Funera	1 Home P	. A .		
			3		0		T.C	pnaconi	no. MD 1	21539				
	Observatoria		shock, or he	ert feilure. List o	complications that cause on each	sed the deeth. n line.	Do not enter	r the mode of c	dying, such as cerd	liac or respiratory	errest,	Int	proximate ervel Between iset end Death	
)	Physician /Medical		Immediete Ceuse	(Final	0.1	. 6)	5	77	4			adot ond Bodan	
1	Examiner		diseese or conditi resulting in death)	on	o. Circh				any Bil	ucer of		4	pars	
L		ner				Due to (or s	as e consequ	ence or):				1		
	The law requires that the death certificate be executed at has been signed by the ettanding physician and page 2 should be detached for use as the buriel-trensit	Examiner	Sequentially list of	anditions.	Ь	Due to (or e	es e consequ	ence of):						
90	e exe		Sequentially list of if eny, leeding to it cause. Enter Und Ceuse (Disease o	mmediate erlying										
Box 68760,	ate b	an/Medical	thet initieted event resulting in deeth)	S	С	ence of):								
9 x	ding p	Me	d											
Bo	ettand for us													
P.O.	thet the death red by the etter detached for u	Physic	Pert II. Other eigni		s contributing to death		ing in the und	derlying ceuse	given in Pert I.				cause of death?	
	thet ned by data		Dia	veter	nellit	us				_ 1□	Yes 2□ No	3 Probabi	y 4 Unknow	
of Vital Records,	w requiras theres should be all should be dated	d by	0	-	e Heart	1				24a. We	s en eutopsy		autopsy findings	
000	w rec	Completed	Con	wasp	e Hear	Jack	ure			per	formed?	comple of dee	ole prior to etion of ceuse	
R	The law ta has	E O		4		·				10	Yes 2 No		es 2 No	
ital		0	25. Was case refe	rred to medical					26. Piece of D	eath (Check only			20110	
† <		To B	exeminer?	No	Hospital:	atient 2 El	R/Outpatient	3□ DOA	Other:	Home 5□ Res		ner (Specify)		
	ding Ph h. After th funeral		27. Manner of Dee	th 5 Pending	28e. Date of in	njury 2 Dey Yeer) 2	8b. Time of Injury	28c. ir			how injury occur			
Sio	Uttandir death. ctor: Af y the fu	atic	2 Accident	investiga	ition	, , , ,	,,		☐ Yes 2☐No					
Division	or Attance after deatl Director:	Certification:	3 ☐ Suicide 4 ☐ Homlcide	6 Could no determin	ed 286. Piece of	Injury - At hom etc. (Specify)	e, far <i>m</i> , stree	et, fectory, offic	Э	28f. Location City or To	(Street end Numi	ber or Rurel Ro	oute Number,	
	urs al vral D			1-1										
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier (Check only one)	15d_Certifying 2☐ Medical E	Phyeician: To the best maminer: On the basis	of examinatio	edge, death on end/or inve	occurred et the estigation, in m	time, dete end ple y opinion, deeth oc	ce, end due to the curred et the time	e ceuse(s) end me, date end place,	enner es stete end due to the	d. ceuse(s)	
	ithin ithe	Mec	29b. Signature and		end manner	SIGIOG.			ense nu <i>m</i> ber		29d. Date signe			
	FRFS		19	m. of	An	5		-	7004			1 99	,	
	5		30. Name and add	ress of percon	ho completed cause of	f death (Itam ?	(3a) /Tuna D		1			, [(-(
	nes		L.R. MILE			ACKSON			NACON	ING N	VID 21	539		
	Sta	te	31. Date filed (Mor		32/Regis	strar's Signatu		1						

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 15 1999 March 12:05 am /Medical **EVANS** BROWN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) if Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2 ☐ F Vrs 218-16-8097 Director 75 February 6,1924 Maryland Usual Residence of Decedant death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits - Phow 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Madical Examinat must be notified at Maryland Wicomico Salisbury TY Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Booth St. 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Dacedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 72 hours aftar 1 ☐ Naver Married 2 ☑ Married Yas 2 No Yes, Give ∆ If Yes, Give Army Year or Dates: WW I altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brown, Donald H.D. Metal Co. Parts Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mantal Moody Dell Brown Edna Hobbs 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona L. Brown/Wife 104 Gurney Dr., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 Donetion 5 ☐ Other (Specify) St. Andrews Episcopal Church Cenetery 3/18/99 Princess Anne, MD 22. Name and Address of Facility MOIOSI Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompoor TOUTE. 23a. Part 1. Enter the diseasa, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be axec Records, P.O. Box 68760 physician Physician/Medical the Dua to (or as e consequence of) 88 use signed by the ald Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? page 2 1 Yes 2 No 1 ☐ Yes 2 1 No Tuc cartificate Division of Vital or Attanding Physician: diractor, Be 25. Was case/referred to medical a 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowladge, death occurred at the tima, data and place, and due to the cause(s) and manner es stated. completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier 14 regeri 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 1999 Registrar Sporks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7520 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year March 20, 1999 Month **Physician** 9:10 AM Charles Lee Bloodsworth /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 12337 Vivan Street Bishopville Worcester Birthplace (Stete or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Days Hours 1♥M 2□ F Months February 25, 1941 Crisfield, MD 58 Director 219-36-5561 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Wedical Examiner must be notified at 1 Yes No Director Worcester Bishopville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12337 Vivan Street 21813 death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Ves 2 □ No 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White λq Year or Dates: Vietnam 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Pages 1 end 2 should be filed within nent of Health end Mentel Hygiene. nt: If item 27 is marked other than ' Elamantary/Secondary (0-12) College (1-4or 5+) Moore, Warfield Glick 18. Mothar's Nama (First, Middle, Meiden Surname) Realtor 17. Father's Name (First, Middle, Last) Be Charles Lee Bloodsworth Sr. Margaret Ward 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12337 Vivan St., Bishopville, MD 21813 Natalie Thomas Bloodsworth/Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any Injury or page. Parsons Cemetery 3/23/1999 Salisbury, MD 21. Signat Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association M01051 23a. Pa 11. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as carollad or respiratory arrest, y. Approximate shock, or heart failure. List only one college on a such line. Intarval Between Onset and Death **Physiclan** /Medical Immediate Cause (Final ESSENTIAL HYPERTENSION EW YEARS disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in death) Last Due to (or as a consequenca of): and Box 68760 physician Physician/Medical 94 Due to (or as a consequence of) # pribnette 85 ö Part II. Other significant conditions contributing to death but not rasulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably ♣ Unknown B bengs d be det À Division of Vital Records. 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2: 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 2 1 Yes 2 No 報 28a. Date of Injury (Month, Dey Year) funeral 27, Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After i or Attending Father death. 1 Natural 5 Pending 1 TYas 2 TNo investigation 2 Accident 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide 24 hours a Funeral 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier edical To the Within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certified 106241 03-22-99 C. Holaworth, M.S.

M.D.

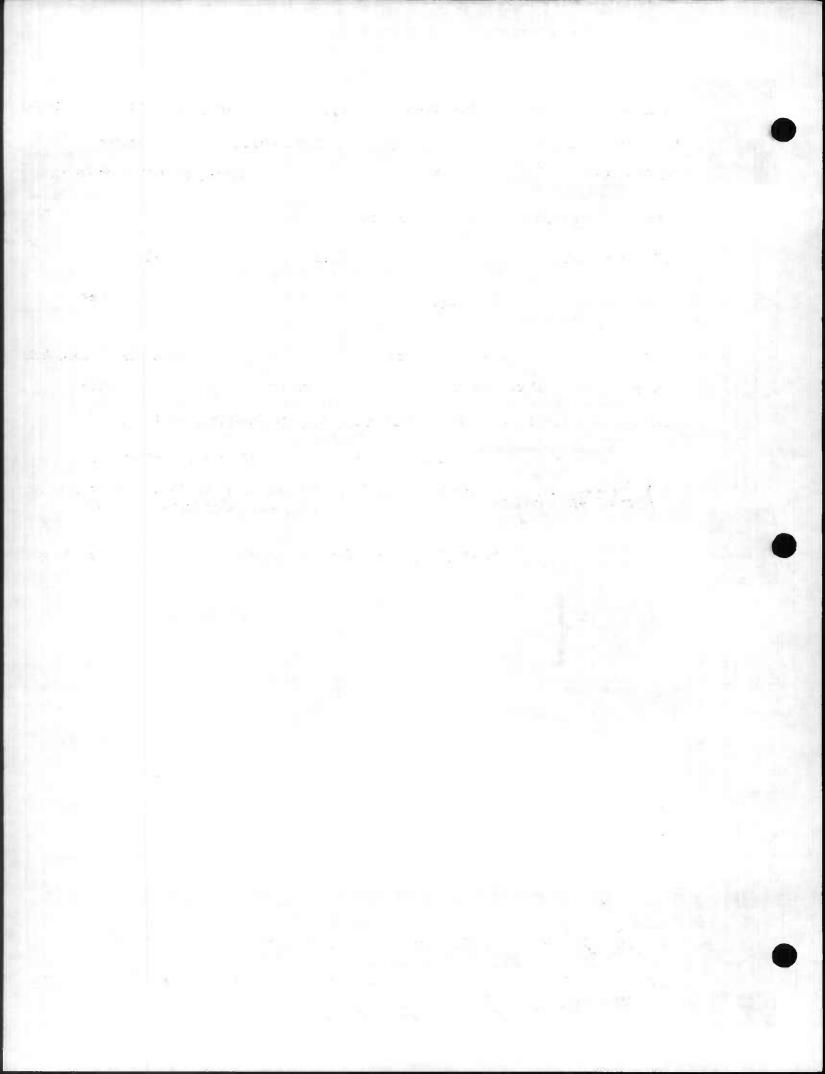
203 SNOW ST. SNOW HILL, MD. 21863

State Registrar DOROTHY

30. Nama, and address of person who completed cause of death (Item 23a) (Type, Print)

ZMOZTH 32. Registrar's Signature

DHMH 16 Rev 6/95



ROBERT BRITTINGHAM

State of Maryland / Department of Health and Mental Hygiene 99

				Ce	rtificate	of i	Death			Reg. No.			
	1. Decedent's ame (First, Midd		LON		2. Date of Death			3. Time of Death					
hysician	ROBER	T BRITT	INGHAM						MARCH 6, 1999			2:40 AM	
/Medical xaminer	4a Facility Name (If not institution ROUTE#29 AT		4b. City, Town, or t ELLICOT						y of Death				
neral ector	219-62-8491 X M 20 F 43 Yrs.				Year	If Under Hours	Min				place (State or Foreig http:/ HILL		
	Usual Residence of Decedent												
ruse Medical Examiner must be notified at ompleted by Funeral Director	10a. Stete 10b. County PRINCE GEORGE 10c. City, Town or Location UPPER MARLBORO											10d. Inside City Limit 1 XYes 2 N	
e e	10e. Street and Number				10f. Zip (Code				10g. Citizen of	What Cou	ntry?	
a la	4408 SUTHERLAND CIRCLE 20772									USA			
The state of	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Yes, Give 7786 1 Yes, Specify: 1 Yes, Give 7786									ce - Americack, White,			
Essention I	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	36	1□Yes 2	[≹No	Specify:			Specify: AFRO-AMER					
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r, the Medical Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)								5.54		1050	
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2	ROBERT	WATERS	,						MARY B	RITTING	HAM G	OMR A	
theath and Mentai hy tem 27 is merked othe other traumatic event, TO Be C	19a. Informant's Name/Relation:	ship (Type, Print)		19b. Mail	ing Address	(Street	and Number	er or Rura	l Route Numb	er, Cify or Town	n, State, Zij	o Code)	
-	DEBORAH P. BRIT	IINGHAM/V	WIFE		DRESS		1E AS	ABOV	E				
to a	20a. Method of Disposition		20b.	Place of Disp cemetery, cre	osition (Name matory or oth	e of her plac	ce)		Date	20c. Location	- City or To	City or Town, State	
ry or	1 Burial 2 Cremation 4 Donation 5 Other (5		Signe S.	T. PAUL	. UMC/	EVE	RGREE	EN 3	-13	BERLIN	N, MD.		
any injury or	21, Signature of Funeral Service	Licensee	CATE	2	2. Name and	Addre	ss of Facili	ty JO	LLEY M	EMORIAL	CHAP	EL	
	1213 JERSEY ROAD; SALISBURY, MD. 21801												
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an	snock, or heart failure. Lis	only one cause or	s ellion line.	1							1	Interval Between Onset and Death	
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er	disease or condition resulting in death)	a	Vinle	DIT	8 1	n	jus	43			1		
e e			Due to	(or as\a conse	equence or):	()				1		
F		b	Due to	(or no n conno	aucano off:						1		
Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		D06 (0	(or as a conse	quence oi).						1		
edicai Examiner	Cause (Disease or Injury thet initiated events	c	Duo to	(or as a conse	auanaa of):						-		
Medi	resulting In death) Last		D06 (0)	or as a conse	quence or).						1		
Physician/Medical Examir		d											
be datached for usa by Physician/N	Part tl. Other aignificant conditi	Part tl. Other aignificant conditiona contributing to death but not resulting in the underlying ceuse given in Pa									ase contribute to the cause of deatl No 3 □ Probably 4 ☑ Unkno		
4	1 -						1			1 Yes 2 No 3 Probably 4			
									24e. Was	an autopsy	24b. W	Vere autopsy tindings	
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page z snouid									h.	_		death?	
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Be	25. Was cese referred to medical examiner? XX Yes 2 No		,			Out	oer.		(Check only				
5				☐ ER/Outpatie		1			me 5 Resi	2 34 3		iy) AT SCEN	
Certification:	27. Menner of Death 1 □ Natural 5 □ Pendi	ng (Mo	te of Injury onth, Day Year)	28b. Time of Injury		Bc. Injui			Describe	how injury occi	Blue	rular	
cati	2 Accident invest	gation 3-	6.00	000	O M		Yes 20	- 14	O V V V V		-	ollisia	
E	3 Suicide 6 Could 4 Homicide deterr	nined 286. Pla	ce of Injury - At Iding, etc. (Spec	home, farm, si	treet, factory,	office			28f. Location (City or To	wn, State)	Der or Rui	rel Route Number,	
				Sh	ret			16	12 29	at St.	John	1 La. Hohas	
Medical Certifica		ng Phystolan: To the Examiner: On the and ma											
Me	29b. Signature and title of certific		\		29c.	Licens	se number			29d. Date sign	ed (Month	, Day, Year)	
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AL.	30 Name col		tupo of dorth (1)	om 92a\ /T	Deint								
IVA	30. Name and address of person	who completed ca	use of death (It			ppt-	. Ral	timo	ne Mar	yland :	21201		
	31. Dete filed (Month, Day, Year	XON	. Registrar's Sig		ou		, Dui	- С.ЩПО.	LC, Mai	-y raiki	21ZUI		
State gistrar	MAR 1 1		Hedistrar's Sign	/	do		, ,						
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and it is the the exerci-

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day **Physician** Yaar 22, 3:00 pm Herbert Edmond Bever 1999 March /Medical 4a. Facility Nama (If not Institution, giva street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** 4005 Beach Drive Chesapeake Bch Calvert

If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth
Months Days Hours Min. | 8. Month, Day, Year) | 9. Birth
(Month, Day, Year) | 9. Birth 5. Social Security Number Birthpiaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1⊠ M 2□ F Yrs. **Director** July 8, 1920 Maryland 579-09-8909 Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat mast be notified at Yas 2 No Director MD Calvert Chesapeake Beach 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? with death Funeral 4005 Beach Drive 20732 USA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after coppartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or iten any injury or other traumatic event, the Medical Examinat Black, Whita, atc. 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 🗓 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Police Officer Federal Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Jessie Mae Walker Owen Frank Bever 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addraas (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Elaine Mello/daughter 255 School Street, N. Kingstown, RI 02852
aca of Disposition (Nama of Data 20c. Location - City or Town, Stata 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 1

Burial 2 □ Cramation 3 □ Ramoval from Stata
□ Donation 5 □ Othar (Specify) 3/25/99 Great Mills, MD Evergreen Mem. Gdns 21. Signature of Funaral Sarvica Licensee 22. Nama and Addrass of Facility Raymond Funeral Home, P.A. P.O. Box 121, Dunkirk, MD 20754 23a. Part1. Ediar tha disaasa, or complications that of used tha death. Do not antar tha mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Box 68760 Physician/Medical Dua to (or as a consequance of): USB BS fo signed by the a P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Yes Records, à 24b. Wara autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy Completed peen has 1 ☐ Yas 2 ☐ No Division of Vital funeral director, 25. Was case refarred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA MOSPILO 28a. Data of Injury (Month, Day Year) 27. Mangar of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Matural if or Attending after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida filled in Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and placa, and dua to tha cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. edical 29a. Certifian (Check only one) To the To the To the 29b. Signature and title 29c. Licansa number 29d. Data signed (Month, Day, Year) MI

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

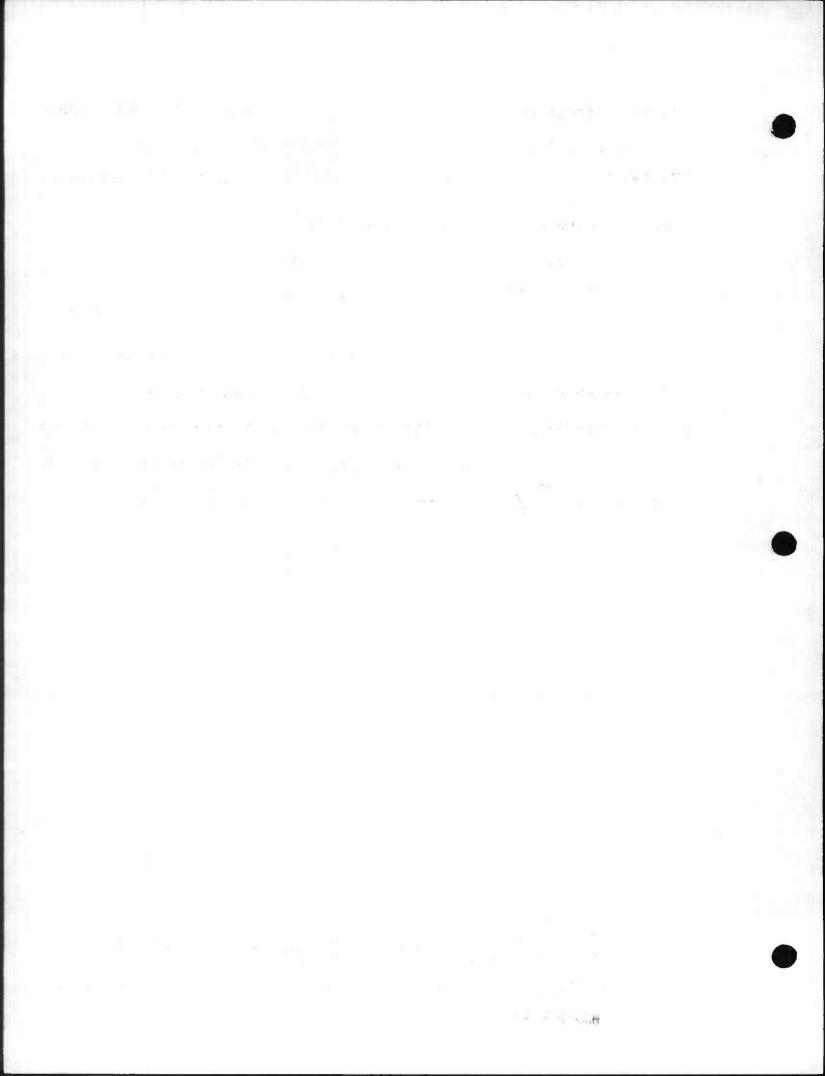
who complated causa of death (Itam 23a) (Type, Print)

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32. Registraris Signature

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10+1



State of Maryland / Department of Health and Mental Hygiene

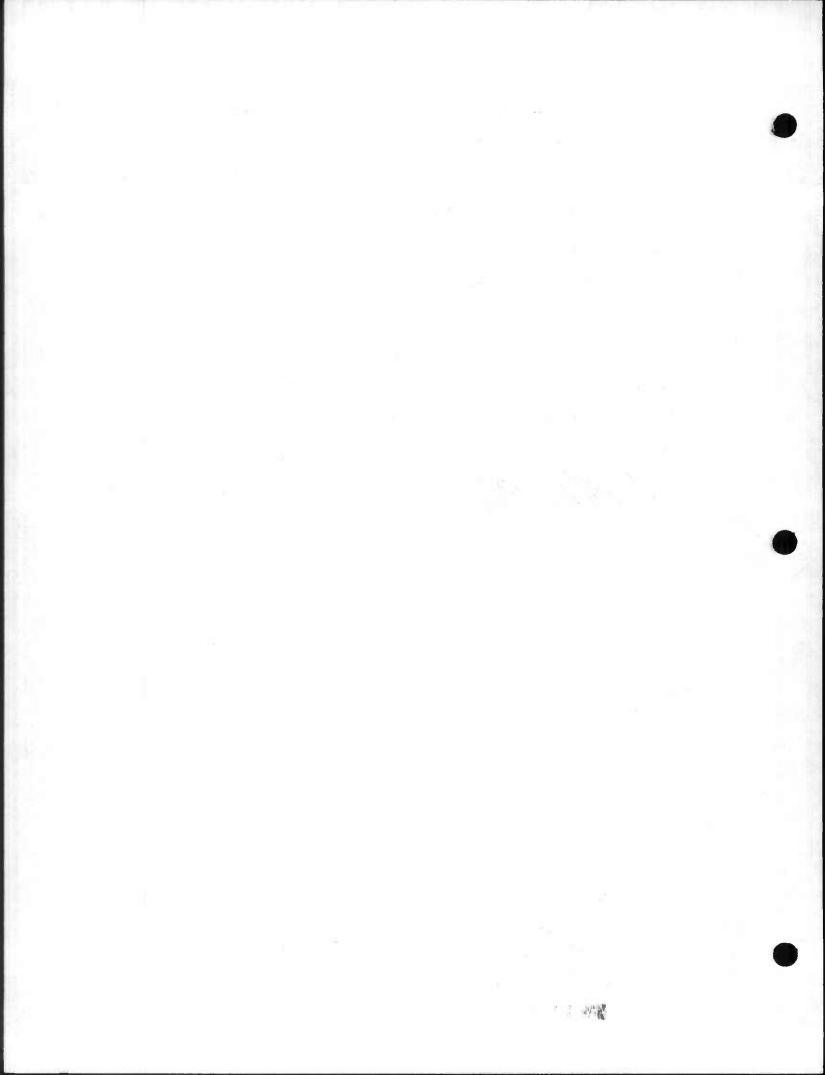
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** James Vivian Bowen March 21, 1999 17 25 /Medical 4a. Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Aga (In yrs. last birthdey) If Undar 1 Yaar | if Undar 24 Hrs. | 8. Data of Birth | (Month, Day, Year) 5. Social Security Number 6. Sax Birthpleca (State or Foreign Country) **Funeral** 1 XM 2 F Months 217 18 2016 Feb. 8, Director MD Usuel Residence of Decedent death with the Meryland 10a. Stata 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiona. Important: If them 27 is merked other than "natural; or items 23a or 28a-f show any injury or other treumstic event, its Mexical Estimines must be notified as 10d. Inside City Limits MD Calvert Huntingtown Director 1 ☐ Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2995 Plum Point Road 20639 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, Whita, atc. 1 ☐ Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) agriculture farmer 17, Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Maurice Issac Bowen Frances Priscilla Denton 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) Alma W. Bowen/wife same as 10 above 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 □ Cremetion 3 □ Removal from State Emmanuel UM Church Cem. 3-24-99 4 ☐ Donetion 5 ☐ Øther (Specify) Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Rausch Funeral Home, Owings, MD Pert1. Entar the diseasa, or compilcations that shock, or heert feiture. List only one causa of such Approximata Interval Between Onset end Death daath. Do not enter the mode of dylng, such es cardiec or respiretory errest, **Physician** /Medical immediata Cause (Finel diseese or condition resulting in deeth) **Examiner** Examiner piration nding physician and use es the bunal-transit be axecuted Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initialed events rasulting in deeth) Lest P.O. Box 68760, End stage Physician/Medical Dua to (or as a consequance of) 189 es signed by the at d be dateched for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown Division of Vital Records. by cate has been signification categories can be categories. 24b. Wera autopsy findings available prior to Completed 24e. Wes an autopsy completion of cause of death? After this cartificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complately filled in by the funeral director; 25. Wes case referred to medical Be 28. Piece of Deeth (Check only one) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 2 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation Nature 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted 29a. Certifier Medicai (Check only one) 29c. Licansa number 29d. Date signed (Month, Dey, Year) 29b. Signeture end titla of certifier 6 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. Prince Frederick, MD 31. Dete filed (Month, Day, Year) 32. Registrat's Signeture State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Dey 1999 **Physician** Month March 18, Briscoe Burdel Bowen, Sr. 17:30 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 4034 Hunting Creek Road Huntingtown | Months | Deys | Hours | Min. | June 19, 1916 | Huntingtown, MD 5. Social Security Number 7. Age (In yrs. iest birthdey) **Funeral** 1**∑**M 2□F Yrs 214 18 2129 82 Director Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at Calvert MD 1 ☐ Yes 2 ☑ No Director Huntingtown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4034 Hunting Creek Road 20639 USA permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, tra Medical Examiner mans once. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: 1945–46 1 Never Merried 2 N Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) farm store manager farm machinery 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Dan Bowen Carrie Bowen 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) same as # 10 above Audrey Mae Bowen, wife 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-20-99 Metropolitan Crematory Alexandria, VA 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility William & Rausch Funeral Home, Owings, MD 23a. Pert1. Enter the disease, or complication, thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only on a see on each line. Approximate Interval Between Onset and Death Physician ACUTE MYECOID CHEKEMIA /Medical Immediete Cause (Finei diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner ettanding physicien and for use es the burlel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probebly 4 □ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed has 1 Yes 1 Yes 22 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this Jurs after death. funeral 27. Menner of Deetr 28e. Dete of Injury (Month, Dey Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital of 24 hours at Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as steted.
2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted. 29e. Certifier Medical (Check only one) To the I within 2 29b. Signeture end title of certifier 29c. License number

8 1 VA

Mukesh N. Mathur, M.D.

MAR 22

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

1999

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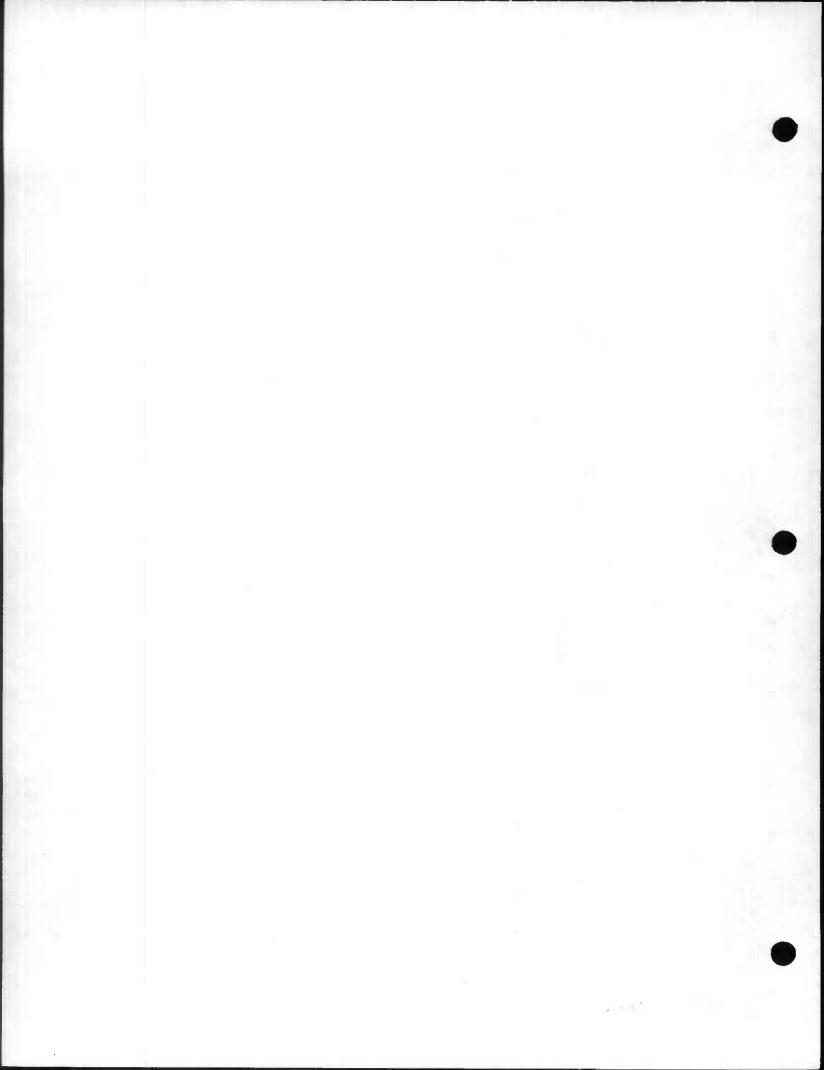
Calvert M.O.B., Suite 305, Prince Frederick, MD 32. Registrar's Signeture

Registrar **DHMH 16 Rev 6/95**

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Dey 1999 Yeer Mar 19, **Physician** Collett 09:10pm Genevieve Lantz /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) **Examiner** Cumberland Allegany Devlin Manor Nursing Home 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV 27, 1906 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** Months Deys Hours 1 M 25 F 234-26-7468 92 Yrs Director Usuel Rasidence of Dacedant the Maryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Manylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be incitited at 15 Yes 2□ No Director Allegany MD Cumberland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21502 USA P.O. Box 270 Funeral 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married altimore. Maryland 21215-0020 1 ☐ Yes Q☐ No Specify: Specify: white þ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Clothing Store 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Gillispie Berlin F. Lantz Madge 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 144D; Keyser, WV 26726 19e. Informent's Name/Relationship (Type, Print) Mr. Berlin Lantz Collett 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/26/ Elkins, WV Maplewood Cemetery 21. Signature of Funerel Service Licansee Scarperin funeral Home P.A. for Lohr-21502Elkins, WV asn Cumberland, Maryland Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or hear failure. List only one cause on each lina. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition resulting in death) CARDIAC ARREST MIKYTE Examiner Dua to (or es e consequence of): Examiner 10 415 CORONARY HEART PISEAJE the buriel-trensit the deeth certificate be executed Sequentially list conditions, if eny, laading to immedieta causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in daeth) Lest Due to (or es e consequenca of): and Box 68760. attending physician for use es the burie Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. deteched P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown SENILG DEMGNYIA Division of Vital Records. þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Completed peen completion of cause of deeth? hes this certificate ! 1 Yes 2 No 1 Yas 2 No 25. Was casa rafarrad to medical examiner? Be 26. Placa of Daath (Check only one) To Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Panding Investigation 1 Natural or Attending efter death. Director: Aft 1 Yes 2 No 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicida To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifier 1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, In my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 23334-D M.8 MARCET 2 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) iB. SHAH, M.D MEZMHET HTS MED BUDG, CUMBERLAND, MD 205 31. Deta filad (Month, Day, Year) 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Yaa **Physician** March 15, 1999 9:25 PM CULVER /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 428 Monticello Ave. Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours **Director** 214-18-4040 83 March 15, 1916 Maryland Usual Residence of Decedent the Merylend 10a. Stete 10c. City, Town or Location 10d. Inside City Llmits 10b. County th and Mantel Hygiene. 7 is marked other than "natural", or fierna 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified as 1 No Yes 2 No Maryland Wicomico Salisbury Directo 10g. Citizen of Whet Country? 10a. Street and Number 10f Zip Code death with 428 Monticello Ave. 21801 USA Funeral 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Black, White, atc. filed within 72 hours efter 1 ☐ Yes 2 🔯 No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Yeer or Dates: Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Glen Ave. Elementary Elementery/Secondery (0-12) College (1-4or 5+) School Food Service 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health end Mentel Hant: If item 27 la marked oth jury or other traumatic even Be William T. Hopkins Sadie Thomas 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Manda Lee Davis/Daughter 428 Monticello Ave., Salisbury, MD 21801 20b. Plece of Disposition (Neme of cemetery, cremetory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Buriei 2 ☐ Cremetion 3 ☐ Removel from State 3/20/99 Salisbury, MD Parsons Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility of Funeral Service Licenses M01051 Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, in the disease on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceusa (Final walk. disease or condition resulting in deeth) Examiner Due to (or es e consequenca of Examiner The law requires that the deeth certificate be executed physician end s the buriet-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Dua to (or es e consequença of): Physician/Medical Due to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown Will monna by 24b. Were eutopsy findings available prior to completion of cause of deeth? should should 24a. Wes en eutopsy performed? Completed is certificete has I director, pege 2 s 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) funerel 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Neturel 5 Pending s efter dec. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, State) in 24 hou. The Funeral Direction of the filled in by 4 Homicide 5 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. (Check only one) 29d. Date signed (Month. Dev. Year) 29b. Signeture end title of certifier 29c. License number

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture MAR 1 8 1999

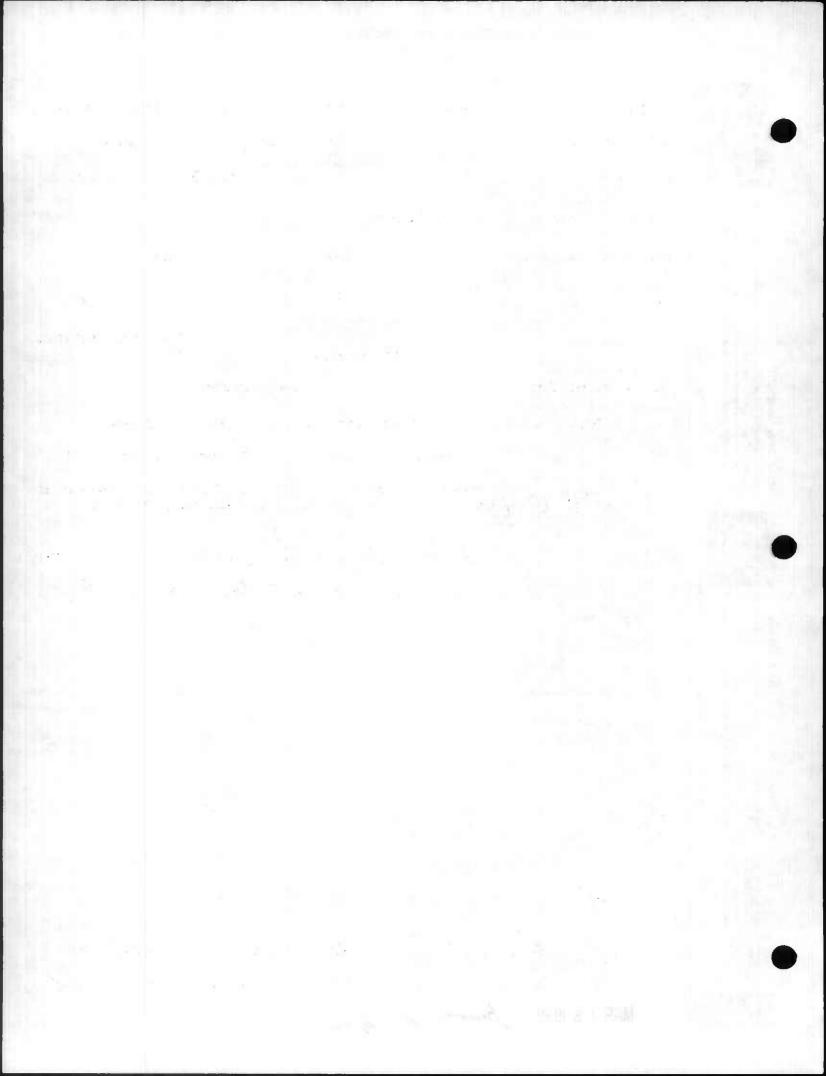
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** Year ETHELBERT JOHN HENRY COLLINS 15,1999 1317 March /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner PENNINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. AUG • 13, 1938 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** 1□M 2□F Months WESTOVER, MD. Yrs Director 60 214-36-5467 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macical Example maint on notified at 1 Tes 2 No Director SOMERSET MD. WESTOVER the 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? 21871 8898 WEDDA ROAD. **HSA** Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 17 Yes 2 No If Yes, Give Year or Dates: 56-59 "natural", or Specify: AFRO-AMERICAN þ 3 Widowed 4 Divorced be filed within 72 hall Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DETARY UNIT Elementary/Secondary (0-12) College (1-4or 5+) SALIS. ST. UNIV. LABORER 12th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fi and Mental H is markad ot MARIAN E. MILBOURNE ARTIE M. COLLINS 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health as Important: if item 27 is any injury or other traus. 834 SABINA CIRCLE, BEAR, DEL. 19701 DIANA HAYES/DAUGHTER 20b. Place of Disposition (Name of cametery, cremetory or other place) TESUS UNITED CHURCH OF LURB 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 3-20 WESTOVER. MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Feneral Servica Licanses JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai Examiner Physiclan/Medicai Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events Due to (or as a consequence of): resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? No No 3 Probably 4 Unknown hepatitic þ 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? has Yes 2□ No 1 Yes 2□ No

Box 68760. P.O. Records, certificate Division of Vital

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To the Hospital o within 24 hours aft To the Funeral Di completely filled in

MD.

Baltimore, Maryland 21215-0020

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Completed Be 2 Medical Certification:

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Naturel
2 Ascident

3 Suicide

29a. Certifier

4 THomleide

Hospitel: 5 Pending investigation

6 Could not be

28b. Time of

Inpatient 2 ER/Outpetient 3 DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

26. Piece of Death (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner steted. 29d. Date signed (Month, Day, Year)

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29b. Signature end title of certifier

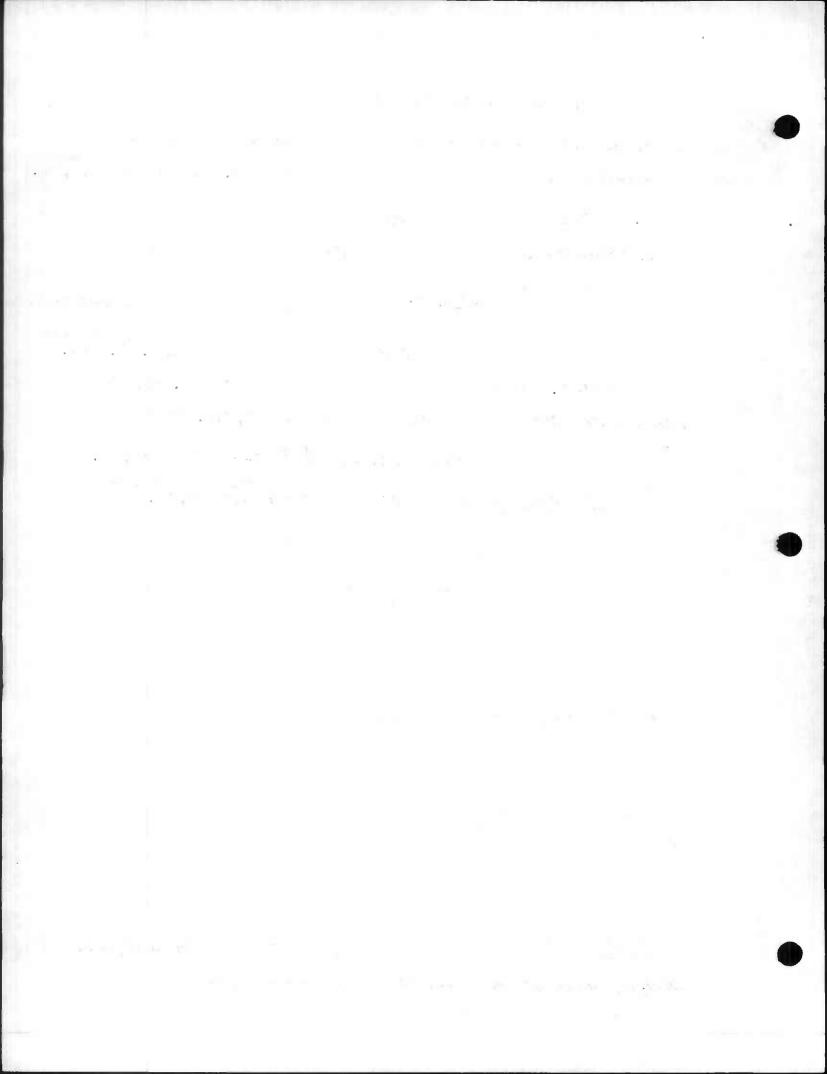
MAYCH 18, 1999

ress of person who completed cause of deeth (Item 23e) (Type, Print)

104 MILLOS ST Huddleston, M.O. Christijon 31. Dete filed (Month, Dev. Year)

State Registrar

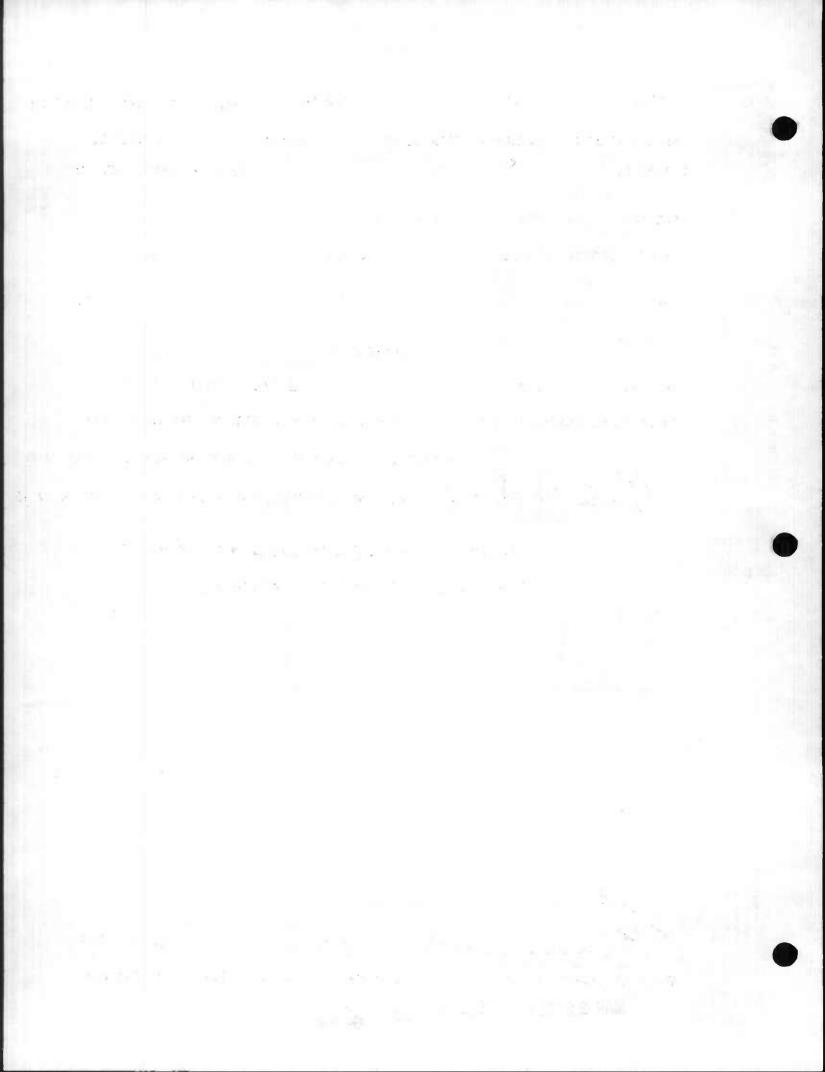
32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

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8 6 2 2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date 200. Location -	20c. Location - City or Town, State												
permit. Peg Department Important: II any injury o	4 Donation 5 Other (Specify) BISHOPVILLE CEMETERY 3/24/99 BISHOPVILLE,														
permit. Pe Departmen Important: any injury once.	21. Signature of Pineral Service Licensee 22. Name and Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19														
	23a. Part Enter the disease, or complications that caused the omith. Do not enter the shock, or heert feilure. List only one cause on each line.	e mode of dying, such as cardia	ic or respiratory arrest,	Approximete Interval Between											
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/Medical	Immediate Cause (Final disease or condition	ARRIVOYASCI	WAR INSERS	3											
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	290. Signature and title of certifier	29c. License number	29d. Date signe	d (Month, Day, Year)											
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0	EDWIN CASTANEDA, MD.D. 9714 HEALTHWAY	DRIVE BERLIN	MD 21811 410-0	641-0646											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedenf's Name (First, Middle, Last) 2. Date of Death **Physician** (harlotte Esther Clark March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. 8. Date of Birth Hours Min. (Month. Day, Year) If Under 1 Year Months Deys 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 224-28-8357 1□ M 2 F Director Usual Residence of Decadent 10e. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at inginia Accomack New Church 10e. Street and Number 10f. Zip Code 33371 Garland Taylor Road 23415 12. Wes Decedent Ever in U,S. Amed Forces? 12 Yes 2 No If Yes, Give 1953-1974 Year or Dates: 1953-1974 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorcad Decedent's Usuel Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Anesthesiologist permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event. It 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Watson Edward F. Laura 19a. Informant's Name/Reletionship (Type, Print) Addie (Jaylor Sister 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 3337/ Garland Taylor Road New Church, Virginia 23415 harlotte 20b. Pleca of Disposition (Name of 20a. Method of Disposition 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from State John Taylor Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Saluer duteration Mome 23a. Part1. Enter the disease, or comprications that caused the deeth. It not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

20c. Location - City or Town, State Dete 3-17-99 Temperanceville, Chincoteague, Virginia 23336 Approximate Interval Between Onset and Death comia Due to (or as a consequence of): Roll mon/a Due to (or es a consequenca of) Sarcajolosis Due to (or as e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No

26. Place of Deeth (Check only one)

28c. Injury et Work?

🗹 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date end pleca, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Dete of Injury (Month, Day Year)

32. Pegistrer's Signature

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Month

3. Time of Deeth

2156

9. Birthplece (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

Vee

1989

WICOMICO

4c. County of Death

10g. Citizen of Whet Country?

14. Raca - American Indian,

Bleck, White, etc.

Specify: White

16b. Kind of Business/Industry

U. S. Navy

13

Physician /Medicai **Examiner**

Immediate Ceuse (Final

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

25. Wes case referred to medical

29b. Signature end title of certifier

31. Date filed (Month, Day, Year)
MAR 1 6 1999

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1 Yes 2 No

27. Menner of Deeth

1 Natural

2 Accident 3 Sulcide

4 - Homicide

29a. Certifier (Check only one)

disease or condition resulting in death)

burial-transit P.O. Box 68760, the à Records, r this certificate hes been si Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica 3 To the Hospital C. within 24 hours effer To the Funeral Dire

Physician/Medical

þ

Completed

Be

Certification: To

Medicai

State Registrar

NE (25) 100 William I was the set of the transfer of the set of the Pilipe et wittinger appliet ogsåtet get til g

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Day **Physician** SARAH Mae March 10, 1999
ocation of Death 4c. County of Deeth Davis 11:45 PM /Medical 4a Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death **Examiner** Salisbury Center: Genesis ElderCare Salisbury, MD 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar | if Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) **Funeral** Hours 1□M 2\ F Months Deys Director AUG. 23, 1897 MARYLAND 218-07-2711 101 Usual Residence of Deceden with the Marylend 10a Siala 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at TV Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 200 IVIC AVE itema 23a U.S.A. Funerai 21804 death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ∑ No If Yes, Give Yaar or Datas: 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Rece - American indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. If them 27 le marked other than "natural", or item 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: P 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) BEAUCHAMP MARY JONES 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 19e. Informant's Name/Ralationship (Type, Print) ROBERT E. DAVIS - SON 210 WORCESTER ST. #304 OCEAN CITY, MARYLAND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1X Burlel 2 ☐ Cremation 3 ☐ Removel from State Injury or

Physician /Medical Examiner

4 ☐ Donetlon 5 ☐ Other (Specify)

of Funeral Servica Lican

30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

William H. Robins, M.D.

MAR 12

31. Dete filed (Month, Day, Year)

Saltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending chrosician and

physician and s the burial-trans Medical Certification: within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

Division of Vital Records, P.O. Box 68760,

D. Kell	mpm (F BOUND	S FUNERAL HO	OME, INC. SALIS	BURY, MD 21804
23a. Pert1. Enter the disaasa, or comp shock, or heert feilure. List only	plications thei caused he dae one cause on each line.	th. Do not enter the mo-	de of dying, such es cardie	ac or respiretory arrest,	Approximele tntervel Between Onset end Death
Immediate Cause (Finel disease or condition resulting in deeth)	Pare	mer	>		dags.
	b. Dane	or as a consequence of)			42
Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or es e consequence of)			
that initiated events resulting in death) Last	Due to (or as a consequance of):			
	d				T T
Pert ff. Other eignificant conditions or	ontributing to death but not ra-	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use con	ntribute to the cause of death 3 Probably 4 Unknown
				24e. Wes en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
				1 □ Yes 2 □ No	1 ☐ Yes 2 ☐ No
25. Wes case referred to medical axaminer?	Manaitali			eeth (Check only one)	
1 ☐ Yes 2 ☑ No		ER/Outpatient 3□ D	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Mennar of Death 1 ☑ Neturel 5 ☐ Panding 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Pleca of Injury - At h building, etc. (Special	nome, farm, street, fector	y, office	28f. Location (Street end Numb City or Town, Stete)	er or Rural Route Number,
29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	yeicien: To the best of my kniner: On the besis of examine and menner steted.	owledge, deeth occurred ation and/or investigation	et the time, date end plec , in my opinion, deeth occ	ea, end due to the ceuse(s) end me curred at the time, date end pleca,	enner as stated. and dua to the cause(s)
29b. Signetura and filla of certifier	1	29	c. License number	29d. Date signe	d (Month, Dey, Year)

WICOMICO MEMORIAL PARK

22. Neme end Address of Fecility

3-15-99 SALISBURY, MARYLAND

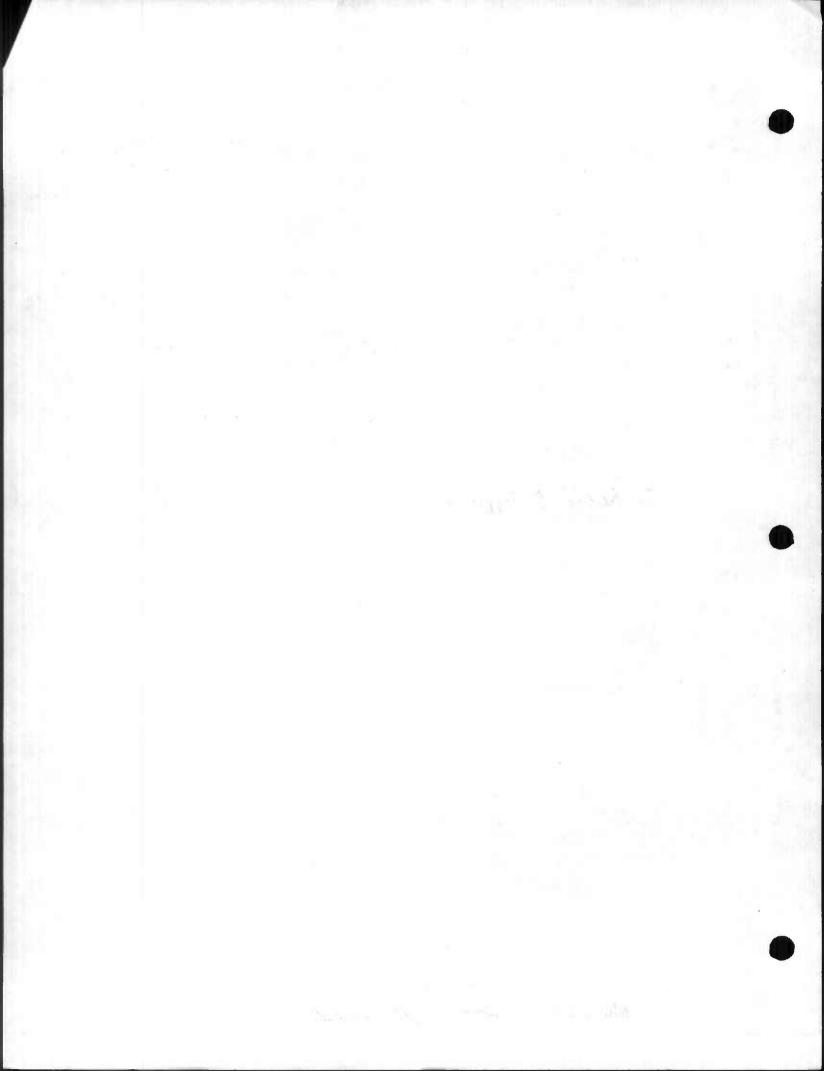
705 E. MAIN ST.

State Registrar

1104 Healthway Dr.

D 29349

Salisbury, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** CURTTS **EMERICK** March 16, 1999 9:45 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 7676 Maple St. Pittsville Wicomico 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 □ F Months Yrs. 215-36-0058 57 Director September 27,1941 Pennsylvania Usual Residence of Decedent the Marylend 10d. fnside City Limits 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No Director Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7676 Maple St 21850 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ff Yes, Give Year or Dates: Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 15th Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) al Hygiena. Elementary/Secondary (0-12) Collaga (1-4or 5+) Perdue Farms Laborer permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: if Item 27 is marked othe any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Oliver Scott Emerick Lydia Mae Emerick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Sylvia K. Emerick/Wife 7676 Maple St., Pittsville, MD 21850 20b. Place of Disposition (Nama of cemetery, crematory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State 3/19/99 Pittsville, MD Pittsville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01051 Holloway Funeral Home Professional Association avid 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only one cause of each line.

An Annual Complex Co Approximete fntarval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Metastatic Examiner Due to (or as a consequence of): Examiner Bue to or as a consequence of): physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last deeth certificata be exec Physician/Medical Due to (or as a consequence of): Ses esn 0 23b. Dfd tobacco use contributa to the cause of death? Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown ped ped ped ped Division of Vital Records. 2 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of death?

peen page 2 hes certificata director. this funeral Aftar

Completed Be O_L Certification:

or Attending efter death. Hospital 24 hours e Funeral (To the Hosp within 24 ho To the Fune completaly fi

13

State Registrar

edicai

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

28b Time of

29c. License number 125005

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and addrass of person who completed ceusa of death (Item 23a) (Type, Print)

Hospital:

1104 Health way Or Salichon, mp 21804 Rather re 5m0

31. Data filed (Month, Day, Year) MAR 1 8 1999

5 Panding

Investigation 6 Could not be datarmined

25. Was case referred to medical examiner?

29b. Signatura and titla of certifier

1 Yes € No

27. Mannar of Death

1 Natural 2 Accident

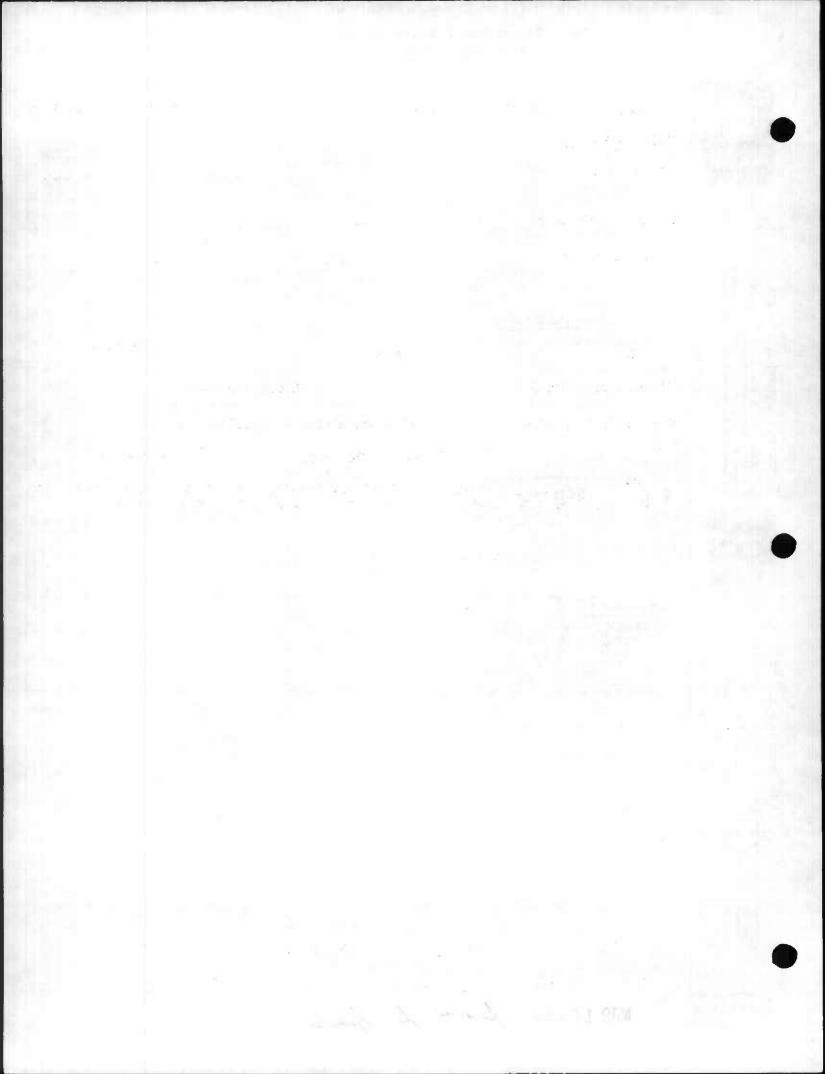
3 ☐ Sulcide

29a. Cartifier

4 Homicide

(Check only one)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of M

in in place inacipie inie. Vaane Vii o	opies Are Legible.	
laryland / Department of Health and Ment	tal Hygiene 99	1051
Certificate of Death	Reg. No.	10031

Physicia /Medica Examine

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 28 or 28a-f show any lighty or other traumatic event, the Medical Examinar mant be notified at anones.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

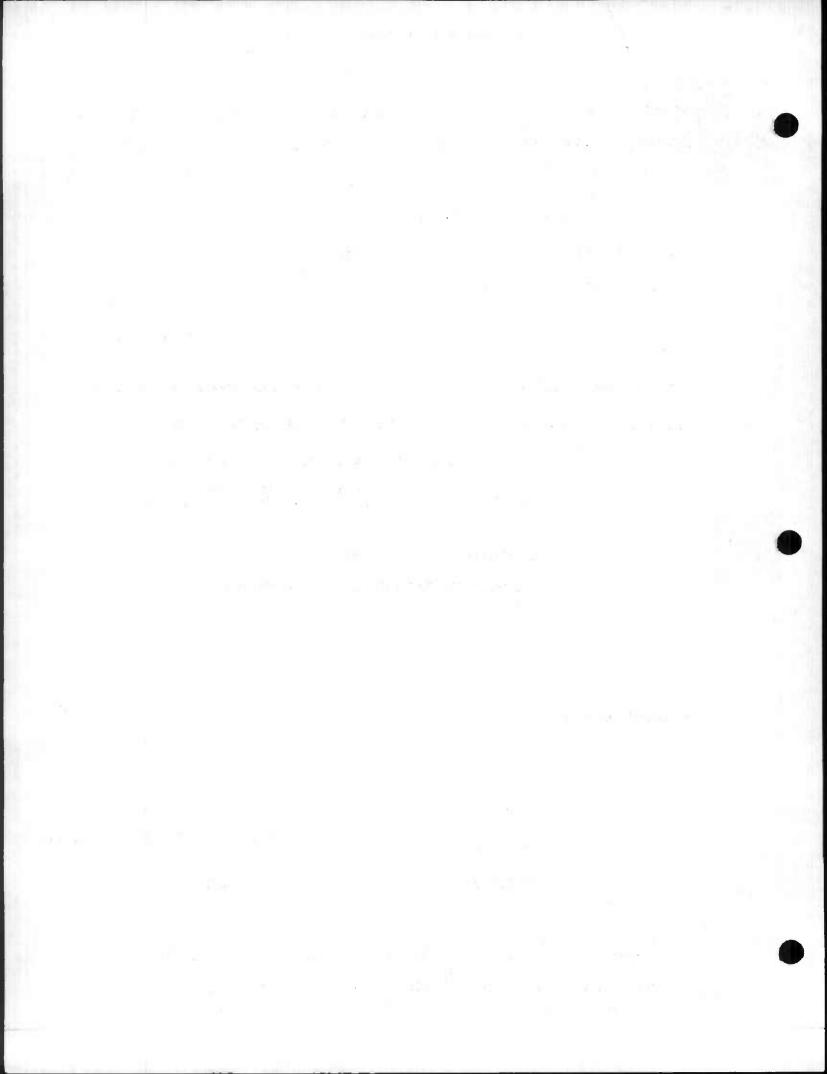
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit

Division of Vital Records, P.O. Box 68760,

					Certifica	ite of	Death			Reg. No.			
1. Decedant's Nama	(First, Middla,	Last)							2. Data of De	eath		3. Tima	of Death
JOSEPH	N.				DE E	TORR			Month	Day	Year	0645	
4a. Facility Nama (If r		aiva street and nu	mber)		بابانتا	IOTT	4b. City. Tow	n. or Lo	O3- ocation of Daat	15-	ounty of Dear	0645	
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PENINSULA					of a lift Lind	ar 1 Yaar	SALISBU If Undar 2				COMICO		
5. Social Sacurity Nu		6. Sax 1X M 2 F	7. Aga (In yrs		Month:		Hours	Min.	8. Data of Bir (Month, Da	th y, Year)	9. Birl	hplaca (Stata	or Foraig
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Usual Rasidance of E 10a. Stata	-		40- 0	ite Tarre								1	
	10b. County				or Location							10d. Insida	
De.	Sus	ssex	De	elmar								1 ∐ Ya	s XII N
10e. Street and Numb	bar				10f. Z	lp Code				10g. Citize	en of What Co	untry?	
Rt. #2 Bo	ox 238					1994	0			US	Α		
11. Marital Status		12. Was Dao	edant Evar in I	J.S.				in? (Spe	ecify Yas or No		I. Race - Ama	ricen Indian.	
1 Nevar Marria	d XX Marrie	Armed Fe		,	If Yas, sp	ecify Cub	an, Maxican,	Puarto	ecify Yas or No Ricen, atc.)		Black, Whit		
3 ☐ Widowed 4		If Yas, G	va		1 🗆 Yas	2 ∑ No	Specify:			S	pecify: T.Th	440	
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(Specify	Decedant's y only highest	grada complated)		108. [Dacedant's Us 'Giva kind of w lifa. DO NOT	ork dona	during most	of worki	ing		d of Businass/	,	
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10				Far	mer		1				etable	S	
17. Fathar's Nama (F.									(First, Middle		•		
William N	Vorris	Elliott					Armin	a E	thel Ch	nipman	n Ellic	ott	
19a. Informant's Nam	ne/Relationshi	ip (Type, Print)		19b. I	Mailing Addra	ss (Stree	and Number	or Rura	al Routa Numb	er, City or	Town, Stata, 2	Zip Coda)	
Grace Tas	ker n	aughter		Bi	0#2 Bos	2 2 2 2	C Delm	ar	De. 19	940			
20a. Mathod of Dispo		augnter	20b.	Place of [Disposition (N	ama of		iai,	Data Data		etion - City or	Town, Stata	
1X Burial 2 □	Cramation	3 □Ramoval from	State	_	, cramatory or			1			,		
4 Donation 5			La	urel	Hill (-18-99	Laur	cel, De	₽.	
21. Signatura of Funa	aral Sarvice Li	icensaa					ss of Facility		Tmo				
aloo o	W D	anniojan					eral H		, inc. lmar, I) a 10	10/0		
23a. Part1, Entar tha shock, or haart	disaasa, or o	complications that	aused tha das	ith. Do no							7740	Approxima	ata
shock, or haart	tamura. List o	nly ona ceusa on	each line.									Onsat and	atween
Immediate Ceuse (Fi	inal												
disaasa or condition rasulting in daath)		a CONGE	STIVE I	HEART	FAILU	RE							
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that initiated avents	100	С	Dua to (or as a co	nsequance of):							
rasulting in daath) La	ist		550 10 (0. 40 4 00	inocquarioo or	,					1		
		d											
Part II. Other signification	ant condition	s contributing to d	eath but not ra	sulting In t	the undarlying	ceusa gi	an in Part I.		23b. Dld	tobacco u	sa contribute	to the cause	of death
FRACTURED	геет н	TP							1 🗆	Yee 2	No 3□P	robably 4	Unkno
raioroi (ED)	DIL 1 11												
									24a. Was	an autopsy		Were eutopsy availabla prior	
												completion of of death?	
									4.77				٦
				_						Yas 2X	No	1 ☐ Yas 2	J No
25. Was casa raferre axaminar?	d to medical	Hospital:				0.1		of Daath	(Check only	ona)			
1)X Yas 2□ N	0	1 🔼	-	ER/Outp	oatient 3 🗆 🗆	OA ON	nar: 4 Nurs	Ing Ho	ma 5□ Rasi	dance 8	Other (Spe	cify)	
27. Mannar of Death 1 □ Natural	5 Panding	28a. Data (Mon	of Injury th, Day Year)	28b. Tir	ma of ury	28c. Inju Wo	ry at rk?		28d. Dascribe			DOOD	E-73.3 F
2 Accidant	investiga			090	0.4	1 🗆	Yas 2 N	° L.E.I	LL WALK	ING T	HROUGH	DOOR	WAY
3 ☐ Suicida 4 ☐ Homicida	6 ☐ Could no detarmin	28a. Place	of Injury - At I	noma, farn		ry, office		- 1	28f. Location (Number or Ru	ural Routa Nu	mber,
4 LI Homicida			ing, atc. (Space N'S HOL						City or To		MD		
29e, Cartifiar 1	☐ CertifyIng	Physician: To the			death occurre	d at the ti	me dete and		SALISBU			ctatad	
	Madical E	xaminer: On the b	esis of axeminar statad.	ation and/	or Investigation	n, In my	plnion, daath	occurr	ed at the time,	date end p	lace, and due	to the ceuse	(s)
29b. Signatura and tit	tle of contifier	end man	ilai Statau.		2	On Linear	sa number			and Date	nimenal (Mont	h Day Vand	
Los. Orginatura and tit	a or cortillar				2	oo. LIGHIN	w HAIHDAI			Zad. Data	signed (Mont	ii, Day, 1981)	
John	mox	Sould	200.	D.I	M.E. I	00003	3599		0	03-15-	- 99		
30. Nama and eddras	s of person w	ho complated ceus	se of death (_ ~ ~ ~ ~							
						AD C	AT TODE	TDV.	MD 2180	71			
31. Date filed (Month,			lagistrar's Sign		OFF_ROM	יו וער	ומכידיהטר	M.I.	רוח בדמו	J.L.			
1	WAR 1	7 1999	Gener	a	4	1	No.						
	T YEAR	ן וששש	June		Ø	Ana	Wal						

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Fadele 06:5 16 03 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Baltimore Med Ral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 10 M 2□ F 229-32-1172 Usuel Residence of Decedent Yrs. May 18, Virginia 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Cecil North East 10g. Citizen of What Country? 10e. Street end Number 10f. Ztp Code 112 Red Toad Rd. 21901 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 1 9 5 0 − 7 4 13. Was Decedent of Hispanic Origin? (Specify Yes or Noll Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 💢 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Staff Sergeant Air Force 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Russell Franklin Fadeley Lelia Jane Havens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Betty D'Andelet/Sister 12541 Summerwood Dr. Silver Spring, MD 20904 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 Cremation 3 Removel from Stete 3-20-99 Rising Sun, MD 4 ☐ Donetion 5 ☐ Other (Specify) New Bridge Baptist Cem. 22. Name end Address of Fecility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 0 23e. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Final disease a condition resulting in deeth) Due to (or es e consequence of) paraspinal week(mass Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of) Due to (or es e consequence of): resulting in deeth) Last 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting to the underlying ceuse given in Pert I. 3 Probably 4 Unknown mell fre, usulin dependent 1 Yes 2 No 24b. Were eutopsy findings aveileble prior to completion of ceuse ot deeth? 24e. Was en eutopsy performed? Coronary ordery disease obstructuse primorary disease 1 Yes 2 🗆 No 25. Wes cese referred to medicet exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitet: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

The law requires that the death certificata be assecuted or Attending Physician:

ettending physician and for use as the burial-transit signed by the been signated has t certificate this : After this A 24 hours effer Geau...
the Funeral Director: Aft within 2 To the

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

marked other

h and Mental I

permit. Pages 1 and 2 at Department of Health an Important: If Item 27 is n

Physician

/Medical Examiner

Physician/Medical Examiner

by

Completed

Be

2

Certification:

edical

4 Homictde

(Check only one)

29b. Signature end title of certifier

29a. Certifier

should be filed within 72 hours after

Directo

Funeral

à

Completed

LA

State Registrar

TUB Urenstein

P12461

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29d. Date signed (Month, Day, Year)

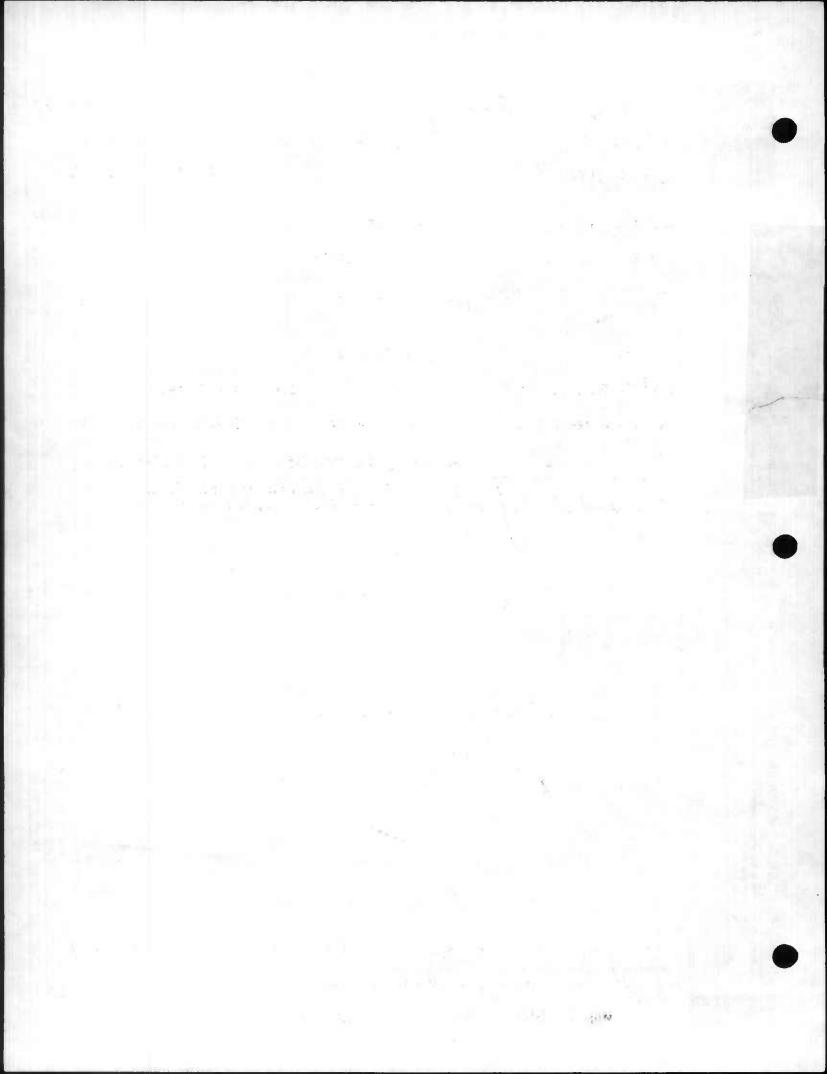
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 North

Greene Street, Baltmary MO 2/201

31. Dete file (Month, Day, Year) MAR 1 8 1999

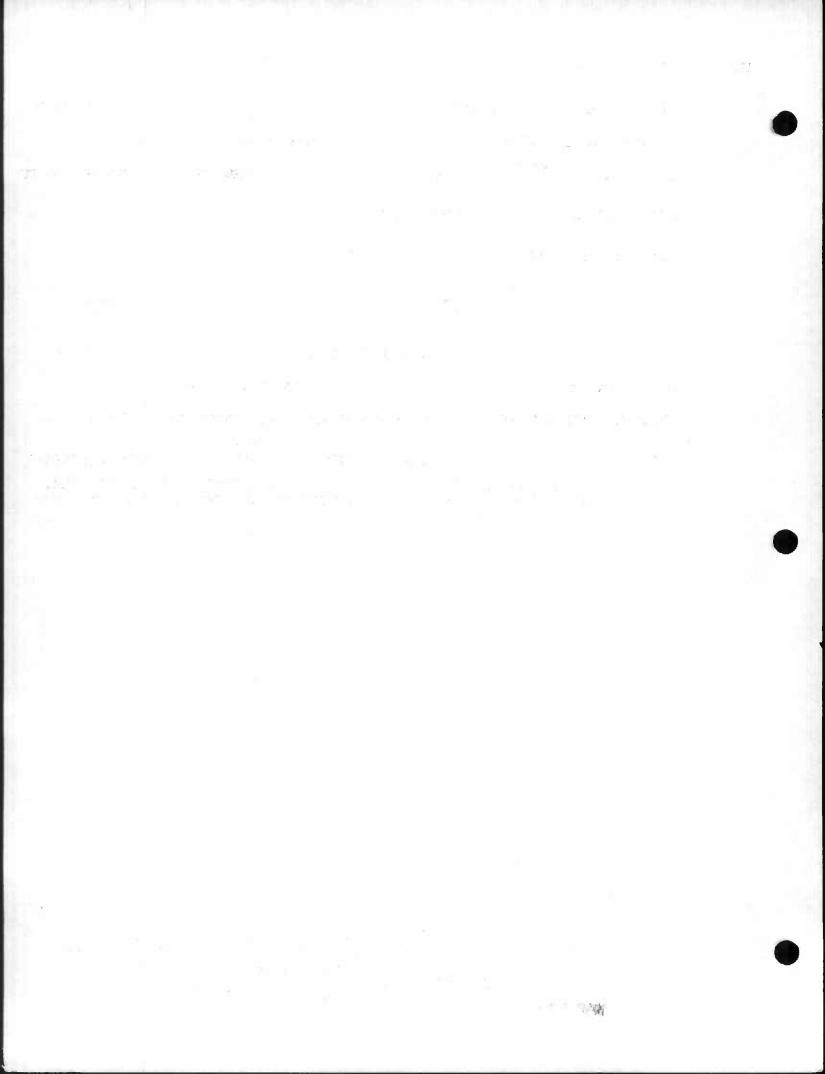
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM:	#7 F	PER F.H. G770 4-8-99 WR	State of Maryla		artment of I tificate of			giene ∫ 🤇 No.		0543
Physic /Medi		Decedant's Nama (First, Middla, Last EARLE EUGENE) FRAZIER				2. Data of Dea Month MARCH	Day	Year 1999	3. Tima of Death 10:10PM
Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or I	Location of Deeth	4c. County	of Death	
F		SOLOMONS NURSING 5. Social Security Number 6. Se		s. last birthday)	If Undar 1 Yaer	SOLOMON If Undar 24 Hrs.		DEC. 24	VERT	ace (State or Foraign
Funeral Director			TAM 2 F	81 Yrs.	Months Days	Hours Min.	DEC 25	1917	Counti	INGTON, DO
and *		Usual Rasidence of Decedant 10a. Stata 10b. County	10c. C	City, Town or Lo	cation				10	d. Insida City Limits
within 72 nous area deed with the Meryland ene. Than "retural", or flams 23a or 28e-f show he Medical Examiner must be notified at	lo	MARYLAND CALVERT		NDERLAN.					10	1 Yas 2 XNo
280	Director	10e. Street and Number			10f. Zip Coda		1	l Og. Citizen of V	Vhat Counti	ry?
23a c		1132 LAKE RIDGE I	DRIVE		20689			U.S.	. A.	
al', or items 23e or 28e-f show Exerciner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forcas? ↑ ★ Yes 2 □ No ff Yas, Give Yeer or Detes: W. W.	1	Vas Decedant of I Yas, specify Cub ☐ Yes 2⁄∑ No	Hispenic Origin? (Spen, Maxican, Puart Specify:	pecify Yes or No- o Rican, atc.)	14. Rac Biac Specify	e - Amarica ek, Whita, e	tc.
jene. r than "natural", or the Medical Exam	Completed	15. Decedant's Edu (Specify only highest grad	ucation	16a. Deced	ant's Usual Occu kind of work done OO NOT use retire	during most of wor	king	16b. Kind of Bu		
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item 27 other tr		20e. Method of Disposition		Pleca of Dispos	sition (Nama of		MARCH	20c. Location -		
nt: H		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla		25,1999	BRENT	WOOS.	MARYLAND
Department of the important: If ite any injury or of once.		21. Signature of Funeral Service Licens		22	. Name end Addre	ess of Fecility LEE ERN MD BI	E FUNERAL	HOME (CALVE	RT,P.A.
nysician Medicai kaminer	Examiner	Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions,								
ed by the ettending physician end detached for use es the buriel-transit	Physician/Medical Ex	Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or Injury that hittated evants resulting in death) Last	cDua to	(or as a consequ	uance of):	ES				
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De de							1□ Y	as 2 No	10	Yas 2□ No
is certificate director, peg	o Be	25. Was case referred to medical axaminar? 1 Yas 2 No	Hospital: 1 ☐ tnpatient 2[750000000000000000000000000000000000000	Ott	har:	eth (Check only or			
After th funeral	atlon: To	27. Manner of Deeth The Netural 5 Pending 2 Accidant Invastigation	28a. Data of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Inju Wo		oma 5 ☐ Rasid 28d. Dascribe h			
within 24 hours ener dear To the Funeral Director: completely filled in by the	Certification:	3 Sulcida 6 Could not be 4 Homicide determined	28a. Place of Injury - At building, atc. (Spec	homa, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, Stata)	er or Rural	Routa Number,
24 hou	edical	29a. Cartifiar TE Certifying Phy- (Check only one) 2 Medical Examt	sician: To the best of my kr ner: On the besis of examin and menner stated.	nowledga, death netion end/or inv	occurred et the ti astigetion, in my	me, data and placa opinion, death occu	, and due to the c rred at tha tima, d	ause(s) end ma lata and plece,	nner es sta and due to t	ited. tha cause(s)
within To the comple	Me	29b. Signetura and titla of certifier	-01	1.	29c. Licans	sa number	2	29d. Data signe	d (Month, D	ay, Year)
		Vose	m1 / 40	M	Do	05224	2	MARCH	+,22	, 1999
		30. Nama and address of person who co		am 23a) (Type, I	Print) 110	005224 O Hospita Prince Sr	u Rd Su	ite 3/0	5	
		JOSEPH JOY		# 111	MU, F	rince fr	ederick	(IM)	206	78
Sta Regista		31. Data filed (Month, Day Year) 2	1999 Sepa		5. So	and 1				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month GIAPES WILDA MAICH 9,20 Pm 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) FACILIT SUNRISE 5. Sociel Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 10 M 20 F Months 233-50-3464 Usuei Residence of Decedent Yrs. · VIRGINIA 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2□No CEC: MALYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21921 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritei Status 1 Neyer Married 2 Married 1□Yes 21 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HomemaKER Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) IN. ROSELLA ANN CATHELINE TO 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BONNIE MIELNIK #80 CONNOR LANC ELXTON MD. 21921 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal trom State 4 ☐ Donetion 5 ☐ Other (Specify) 3/18/199 21. Signature of Funerel Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Intervel Between Onset end Death Immediate Ceuse (Finel te My ocardial Infarction Due to (or es a consequence ot): disease or condition resulting in death) Aproschutic Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown

Physician /Medical Examiner

buriel-transit

Physician/Medical

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Completed

Be

edical Certification: To

end

physicien

signed by the e

certificate

After

To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun.

funeral

Records, P.O. Box 68760,

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

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Funeral

Director

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ŏ itema 23a Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be flied within 72 hours after or Dependent of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or then any Injury or other traumetic event. It is in the context of the c

Saltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case reterred to medical 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time ot 1 Maturel

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. fnjury et Work?

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

ELKTON, MD 2/921

29a. Certifier (Check only one)

4 Homicide

12 Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signeture end title ot certitier > Monte Makous, Mo 29c. License number 44783

March 17, 1999

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

West High Street, MONTE MAKO45

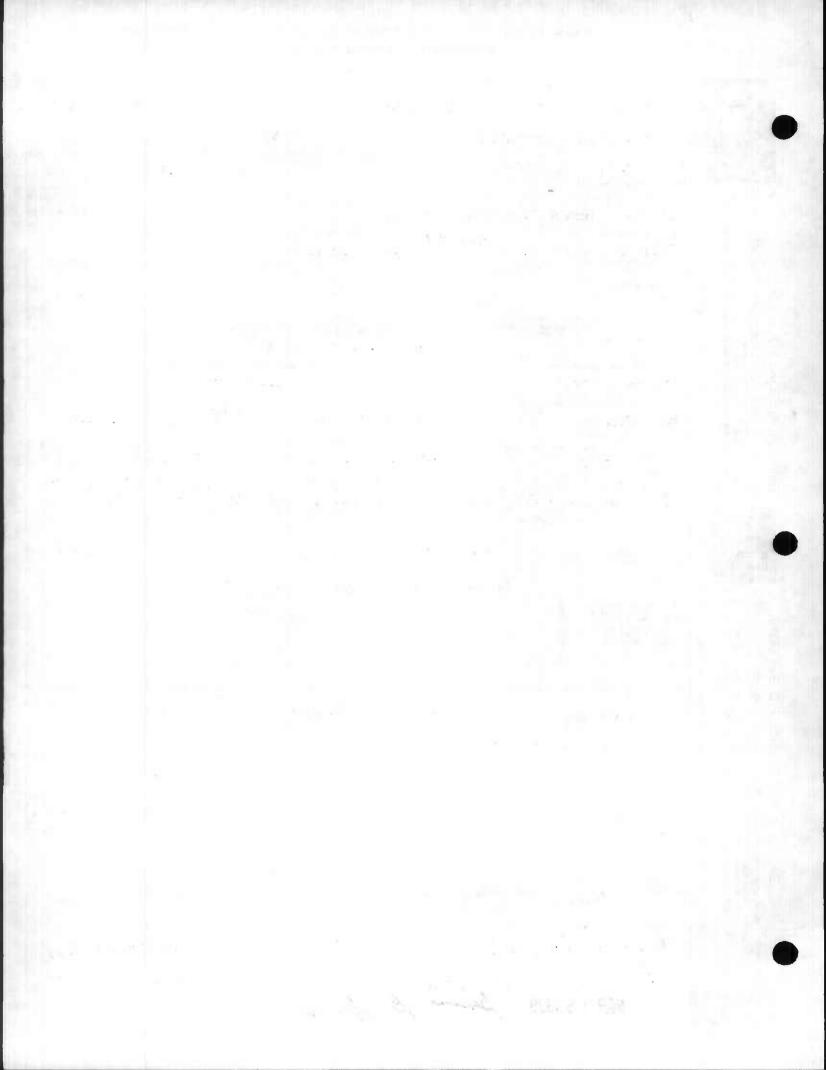
31. Dete tiled (Mooth, Pay Year) 32. Registrer's Signeture

State Registrar

A 3 44-90-1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Sta	ate of Marylan	d / Department of I Certificate of		ental Hygier Reg. i		10545
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Physician /Medical Examiner	GERTRUDE 4a Facility Nama (If not institution, give street		lenberg	4b. City, Town, or Loca	March 12		3:15 PM
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Funeral Director	5. Social Sacurity Number 6. Sax 182–38–5331 1 M 2	7. Aga (In yrs. 88	last birthday) If Under 1 Yaar Yrs. Months Deys	Hours Min.	B. Data of Birth (Month, Day, Yea August 15	9. Birth Cou	olaca (Stata or Foreigr ntry) nsylvania
ytend	10a. Stata 10b. County	10c. City	y, Town or Location				10d. Insida City Limits
Sa-fa	Florida Broward		uderhill				1 Yas 2 No
ifier death with the Mai r items 23e or 28e-f s iteef mail be recited Funeral Director	10e. Street end Number 2251 N.W. 48th Terra	ace Blog #	7 10f. Zip Coda 333	313	10g.	Citizan of What Cou USA	ntry?
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or, o	1 Never Marriad 2 Married 1 (mad Forcas? □Yas 2⊠No Yas, Giva aar or Datas:	1 ☐ Yes 2X No		can, etc.)	Black, Whita,	nite
led within 72 ho ygiene. The than "naturi it, the Medical	15. Decedent's Education (Specify only highast grada com	pletad)	16a. Decedant's Usual Occu (Giva kind of work dona lifa. DO NOT usa ratira	pation during most of working	16b	. Kind ot Businass/Ir	dustry
within the men	Elementery/Secondary (0-12) Co	oltege (1-4or 5+)	Homemaker	ad)		Domestic	
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should bent marked umatice	Nathan Rapoport			Minnie			
D 5 1 2	19a. Informant's Nama/Ralationship (Type, Pr Mona Strauss/	int)	19b. Mailing Address (Straa 12806 Old Br		West		
f Heal f Heal fem 2 other	20a. Method of Disposition		Placa of Disposition (Nama of amatery, crametory or other pla		Data 20c.	Location - City or T	own, Stata
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permit. Pa Department Important: any Injury ance.	21. Signatury of Funeral Stylice Licenses		sociation				
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	23a Part Enfor the disease, or complication shock, or haert teilura. List only ona cau	s that caused the death sa on each line.	n. Do not enter the moda of dy	ing, such as cardiac or	raspiratory errast,		Approximate Interval Batwaan Onset end Death
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ne Hospital or Attending P in 24 hours effer death. The Funeral Director: Affer to pletely filled in by the funeral edical Certification:	3 Cuiside 6 Could not be	Plece of Injury - At he building, etc. (Specify)	oma, tarm, straet, factory, office	28	of. Location (Straa) City or Town, Si	t and Number or Rui tata)	ral Routa Number,
Hospita 24 hours Funera etely fille dical C	(Check only 2 Madical Examiner: O	To the bast of my known the basis of axaminated mannar stated.	wledge, death occurred at the tion and/or invastigation, in my	ime, date end plece, en opinion, daath occurred	d due to the cause d at tha tima, data	e(s) and mannar as and place, and dua	steted. to the causa(s)
To the within To the comple	29b. Signature and limit of the rtifier	4	29c. Licen	se number	29d.	Data signad (Month	Dey, Year)
	1 () South X	1 Mar no	v. D-	05865	m	MRCH 1	3 1999
	30. Nama and address of person who complate	ed causa of daath (Itam	n 23a) (Typa, Print)	N. BAY	C 11		1010
	31. Data filad (Manth Day, Year)	32. Registrar's Signa	R, MO- 164	N. BAY	INOW HI	LL, MD	21843
State Registrar	MAR 15 1999	Service Signa	tura & Spar	61			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) 3. Tima of Death Day Yaar Month **Physician** THOMAS **GROSS** MARCH 14, 1999 0930 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Ray, Year) Dec. 24, 1919 6. Sex 1 → M 2 → F If Undar 1 Yaar 9. Birthplaca (Stata or Foreign 5 Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours 79 Months Days Min. Maryland Yrs. 217-16-5625 Director Usual Rasidence of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiena. Important: If Item Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Exemption. 10a Stata 10c. City. Town or Location 10d. Insida City Limits 10b County 1 ☐ Yas 2 No Calvert Director Maryland Huntingtown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 20639 USA 1695 Kings Landing Road Funeral 12. Was Dacedant Evar In U.S. Armed Forcas? 16 Yas 2 □ No 1941— If Yas, Giva Yaar or Datas: 1946 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Naver Married 2 N Married Specify: Black 1 Yas 2 XNo Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Cement Finisher Construction 18 Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Gross James Orie Martha Coates 19b. Mailing Address (Street and Number or Rurel Routa Numbar, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1695 Kings Landing Road Huntingtown, MD 20639 Gretchen Gross/Wife 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata Young's Cemetery 3/20/99 Huntingtown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Sewell Funeral Home 21 Signature of Funeral Service Licenses 1451 Dares Beach Road Prince Frederick, MD 20678 4. Seine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical Multisystem Examiner Physician/Medical Examiner Netastatic attanding physician end for use as the buriaf-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Ceuse (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): Dua to (or as a consequance of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performad? Completed cartificate has b irector, pege 2 s 1 ☐ Yas 2 💆 No 1 Yas 2 No 25. Was casa rafarred to medical Be 26. Place of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No To 1 Inpatiant 2 ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcida

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. in 24 hours after the Funeral Director: After Funeral Director: After Funeral filled in by the funeral fu edical To the Hosp within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0020

29a. Cartifian

1 Certifying Phyeiclan: To tha best of my knowledga, daath occurred et tha time, deta end plece, and dua to tha causa(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at tha time, dete end plece, end due to tha causa(s) and mannar statad.

29b. Signature and titla of certifiar

29c. Licansa numbar

29d. Data signed (Month, Day, Year)

30. Name and eddress of person who complated cause of daath (Itam 23a) (Type, Print)

10 State Registrar

Varkey Mathew, 31. Data filed (Month, Day, Year) MAR 1 8 1999

32. Registrar's Signatura

Prince Frederick, MD. 20678 Darks

1,000 000000 00000 RELECTION DESCRIPTION THAT EXPLANATION TO THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		AKA Charles Royse (+	Certifica			Re	g. No.	1 4	1941				
Physic	ian	Decedent's Neme (First, Middle, Last CARL GREGO						2. Dete of Deet Month	Dey	Yeer	3. Time of Deeth				
/Medi	ical	4e. Fecility Name (If not institution, give					b. City, Town, or L	March	19 199 4c. County		11:15 am				
Exami	ner	7524 C Street	street end namber)				Chesapeal								
Funeral		Sociei Security Number		(In yrs. last bin		er 1 Yeer	If Under 24 Hrs.		Calve		ce (Stete or Foreign				
Director		579 42 5272	Ž M 2□ F	67	Yrs. Months	Deys	Hours Min.	8. Dete of Birth (Month, Dey, June 23	, 1931	Wash	D.C.				
yland		10e. State 10b. County		10c. City, Town	or Location					100	d. Inside City Limits				
e Me	cto	Maryland Calve	rt			Ches	apeake B	each			1X Yes 2 No				
F 22 E	Dire	10e. Street and Number			10f. Z	lp Code		10	0g. Citizen of W		y?				
s 23a or	ra	7524 C Street	40.114		140.00	2073			USA		. 1				
NOTE, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Meryland it of Heelth and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be not ited.	by Funeral Director	11. Maritel Stetus 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Endemod Forces? 1 X Yes 2 □ Note of Yes, Give Yeer or Detes: 1		13. Was Dec		lispenic Origin? (Spen, Mexicen, Puerto Specify:	Ricen, etc.)		e - Americar k, White, et whit	c.				
2 hour	9	15. Decedent's Edu	cation		Decedent's Us	uei Occup	ation		16b. Kind of Bu						
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Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other than "naturel", or traumetic event, the Medical Exam	Completed	10	Oollege (1-401 54	' ti	le sett	er			const	ructio	on				
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should and Men	2	Ottavio			egorich		Julia I		letti						
Mal d 2 st th and 7 te m traum		19e. Informent's Neme/Relationship (T) Dino O. Gregorich					and Number or Ru oke Rd.,			Stete, Zip C 2011	_				
1 and 1 and Health		20e. Method of Disposition	5011	20h Piece of	Disposition /N	ame of	T		20c. Location -						
P P P		1 ☐ Buriel 2 🕅 Cremetion 3 ☐ F 4 ☐ Donetlon 5 ☐ Other (Specify)		cemeter	y, cremetory or politan	Crem	atory	3-20-99	Alexano						
Dentit. Pe Departmen Important: any injury		21. Signature of Funeral Service Licensee 22. Neme end Address of Facility 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately approx													
Physician		shock, or heart fellure. List only one cause on each line. Onset land Deett													
/Medical Examiner		Immediate Cause (Final disease or condition	11601		Dil	61				1.	S MO.				
LXuillilei	<u>_</u>	resulting in death)	C	ue to (or es a	consequence of):									
nsit	Examiner		b		* .										
icate be executed physician and streets the burial-transit	Exa	Sequentielly list conditions, Due to (or es a consequence of):													
officate be ext physician a as the bunal-	edical	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	C												
X 000 x outifica ding ph		resulting in deeth) Last	d						i						
that the death certificed by the attending pedeched for use as	Physiclan/N							1		i					
at the d	hysi	Pert II. Other significant conditions con	ntributing to death but	not resulting in	the underlying	cause giv	en in Pert I.	23b. Did to	W		the cause of death?				
alres that signed I	by P										ioty 4 dominou				
D se	Completed I		1					24e. Wes en		evail	e autopsy findings lable prior to pletion of ceuse seth?				
The le	mo.							1 □ Ye	s 2 No	10	Yes 2□ No				
	Be	25. Wes case referred to medical examiner?						th (Check only on	e)						
VISION OF VITA Attending Physician: or death. octor: After this certific by the funeral director,	P	1 ☐ Yes 2D No	lospitel: 1 Inpatien				4 Livursing ri	-	nce 6 Othe						
ing P	on:	27. Menner of Deeth 1 Natural 5 □ Pending	28e. Dete of Injury (Month, Dey	Year) 28b. 1	ime of njury	28c. Injur Wor		28d. Describe ho	w injury occurr	ed					
or Attending I after death. Director: After In by the fune	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injur	y - At home fo	M etmat facto		Yes 2□No	28f. Location (St.	reet and Numbe	er or Rural I	Poute Number				
	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	iiii, street, lecto	ry, omce		City or Town		or or ritinari	TODIO TAUTIDOI,				
To the Hospital or within 24 hours after To the Funeral Direction	edical C	29e. Certifier (Check only one) 12 Certifying Physical Control one) 2 Medicel Exami	sician: To the best of nar: On the besis of e end menner stete	examinetion en	, deeth occurred/or investigation	d et the tir	ne, dete end plece, pinion, deeth occur	, end due to the ca red et the time, da	use(s) and me ate and piace, a	nner as stat and due to t	ted. he cause(s)				
ompk	Me	29b. Signeture and title of certifier	(2)	1/11	(11/) 2	9c. Licens	e number	2	9d. Dete signed	(Month, D	ay, Year)				
2		Flyme	4. 87	am,	W/	02	1469	>	3-19	1-99	7				
1 VA		30 Neme end eddress of person who co	ER, MD.	eth (Item 23a) (DSP (TA	1 1	D. 50.11	D. PRIN	CE FR	ENER	100 MD				
Sta Regist		31. Dete filed (Month, Dey, Year) MAR 2 2	32. Registrar	's Signeture	6	10	and 1								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Gardner Barbara Jeane 20, 1999 9:35AM March 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) 9. Binnpie Countr Sept. 24,1931 West 9. Birthplaca (State or Foreign Country) If Undar 1 Yaar 5. Social Security Number 6. Sax If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Days Min 1□M 2K F Months Hours Yrs. Virginia 67 578-42-5258 Usual Residence of Decedant 10d Inside City Limits 10a State 10h County 10c. City. Town or Location 1 ☐ Yas 2 XNo Upper Marlboro Maryland Prince George's 10g, Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S.A. 20772 8905 Columbone Lane 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decadant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 □ Navar Married 2 □ Married White 1 ☐ Yas 20 No Specify: Specify 3 ☐ Widowed * Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Government Elemantary/Secondary (0-12) College (1-4or 5+) Legislative Aide Prince George's Co. 12 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Belcher Russell B. Markle Violet. Tda 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 8905 Columbine Lane Upper Marlboro, MD 20735 Sherry Loenichen (Daughter) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cramation 3 Ramoval from Stata March 25,1999 Ovapa, West Virginia Belcher Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a 271. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) CELL LUNG CARCINOMA NON SMALL Saquantially list conditions, if any, laading to Immadiate cause. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in daath) Last Due to (or as a consequance of): Dua to (or as a consequence of): 23b. Dfd tobacco use contributa to the causa of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 10 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yas No A No 1 Tas 25. Was casa referred to medical axaminer? 26. Placa of Daath (Chack only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pege Department of Important: If Imp Injury or

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mentel Hyglene. In: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show mir. If Item 27 Is marked other than "natural", or Items 20a bondlad any or other traumatic event, has Medical Evanther must be notified at my or other traumatic event, has Medical Evanther must be notified at

Baltimore, Maryland 21215-0020

/Medical

Directo

Funeral

þ

Completed

Be

Examine Physician/Medicai p Completed Be Certification: To

physician and s the buriel-transit ettending pt signed by the e should certificate hes t director, funeral

Division of Vital Records, P.O. Box 68760,

that the death certificete be executed law. Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certific To the Hospital or within 24 hours aft To the Funeral Di completely filled in

29b. Signatura and titla of certifier

27. Manner of Death

Natural

2 ☐ Accident 3 Suicida

4 Homicide

29a. Certifian

28a. Data of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify)

29c. Licensa number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Dascribe how injury occurred

30. Nama and address of parson who complated ceusa of death (Itam 23a) (Type, Print) ROAD #201 CLINTON MS 20735 WOOD YARD 8926 MD

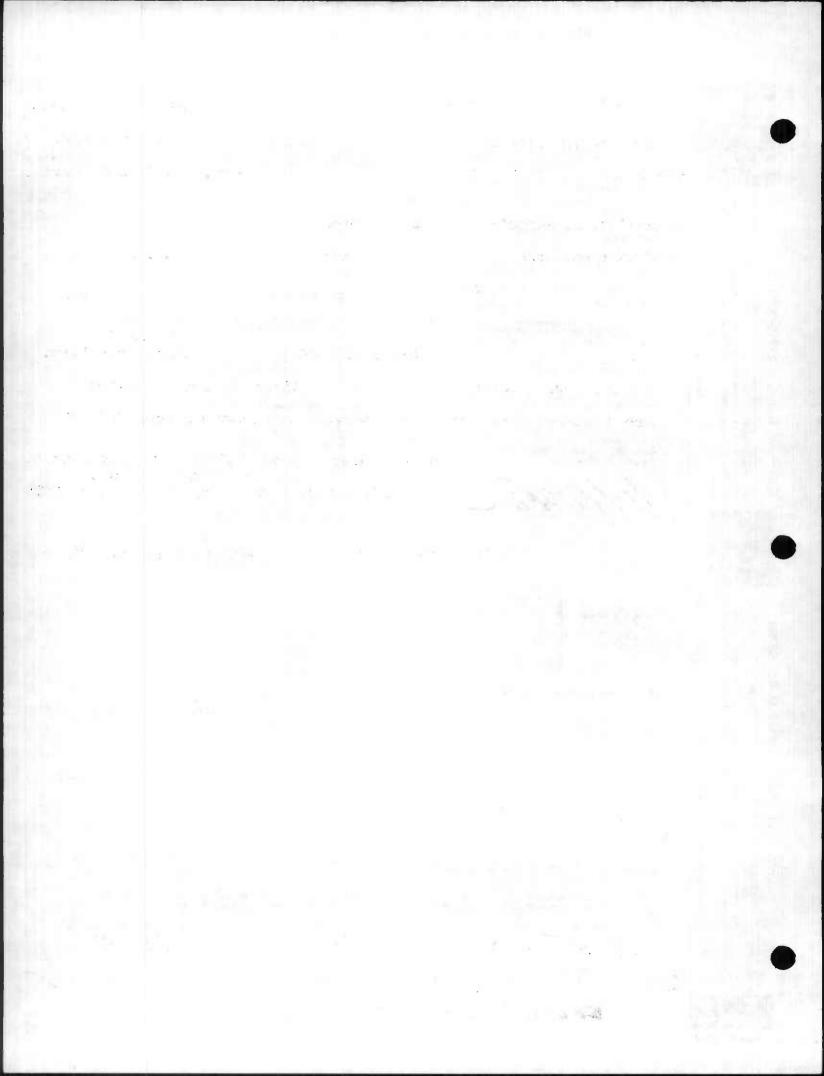
State Registrar

Medical

32. Registrat's Signatura

5 Pending invastigation

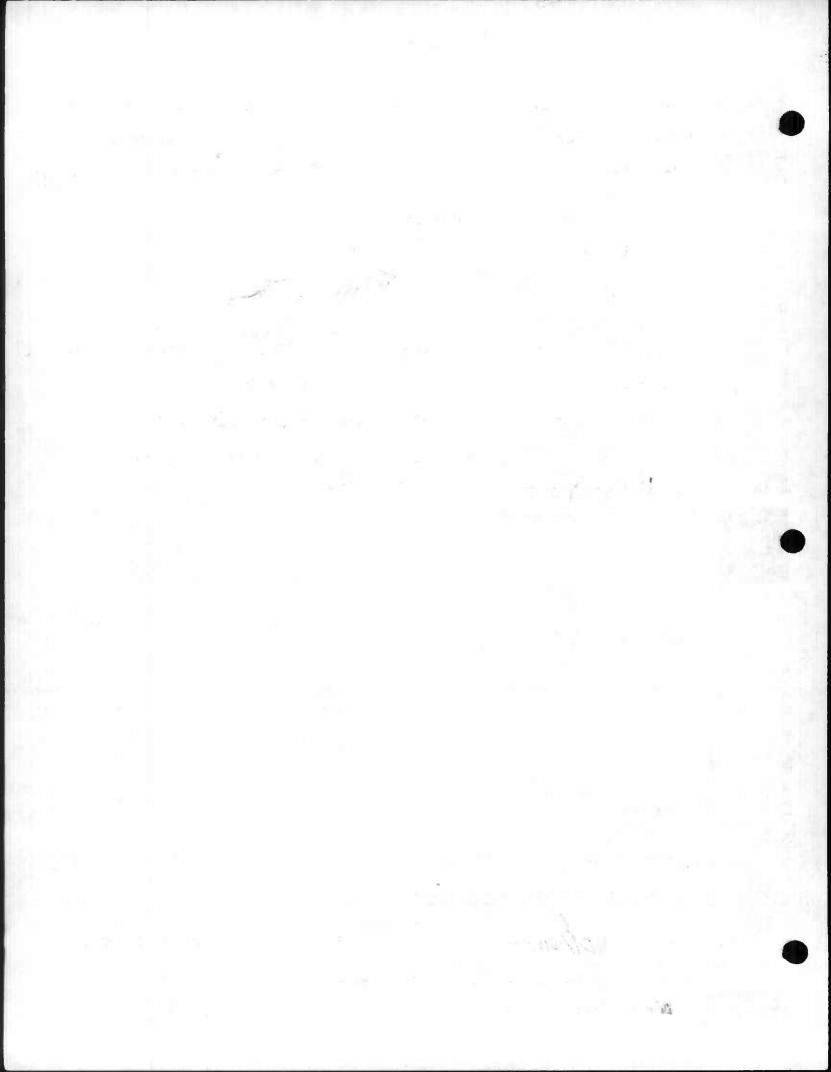
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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nema (First, Middle, La:	et)		Certif	icate of	Death		Reg. No.	1009:			
Physicia					77.	.1		2. Dete of De Month	Dey	3. Time of Do			
/Medic		Terry 4a. Fecility Name (If not Institution, give	Gene		Hur	cley	4h City Town or	March	14 19				
Examin	er	16765 Diggins Roa					Henders		4c. County of				
Funeral Director		241-00-7436	ZIM OLL	(In yrs. last i		Undar 1 Year onths Days			h y, Yee <i>r)</i> 1947 W	9. Birthplece (State or F Country) est Jeffers			
Wot		Usuel Residenca of Decedant 10a. State 10b. County		10c. City, To	own or Location	on			10d, Inside City Lin				
28a-f show	Director	MD Carolin	e	Hend	lerson								
23e or 2	ral Dire	16765 Diggins Ro	ad		1	0f. Zip Code 2164	0		10g. Citizan of Whet Country? USA				
r Health and Membel hygiene I hygiene 128e or 28e-f show from 21 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, in Medical Evaninar must be notified at	by Funeral	11. Maritel Status 1 □ Naver Merriad 2□ Marriad 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:			Decedent of s, specify Cut Yes 2K No		Specify Yas or No- rto Rican, atc.)		Amaricen Indian, White, etc. White			
"neturel", edical Exp	leted	15. Decadent's Ed (Spacify only highest gre		16	Se. Decedent'	s Usuei Occu	petion during most of wo	working 16b. Kind o		ness/Industry			
Mental Hygiene. Parked other than natic event, tra Mi	Completed	Elementary/Secondery (0-12)	College (1-4or 5-			ianager			Lumber	Supply Co.			
d othe	Be	17. Father's Name (First, Middla, Lest)						's Nama (First, Middla, Maiden Surnema)					
narke ratic	2	No Record						. Hurley					
27 is me r treum		Mrs. Darlene R. H						lu <i>ral Route N</i> um <i>be</i> enderson					
Department of Health Important: If Item 27 I any Injury or other troops.		20e. Method of Disposition 1		20b. Pleca came	of Dispositio tery, cremeto	n (Neme of ry or other ple	ece)	Date					
Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licen	see	Del.				3/19/99 neral Ho					
		Harvey C. Smit 23a. Part 1. Entar the disease, or compshock, or heart failure. List only of	To street the Te		1000	N. Du	Pont Par	kway, Ne	w Castle	, DE 19720			
Medical aminer	Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	b. ————————————————————————————————————	ue to (or as	e consequen	ce of):				Years			
		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	C		a consequence								
5 6	sn/Medical	resulting In deeth) Lest	d										
he ett	Physician/	Pert II. Other significant conditions co	ontributing to death but	not resulting	in the under	lying cause gi	ven in Pert I.	23b. Dld t	obacco use contr	ibute to the cause of d			
detect								101	/es 2ÅNo 3	Probably 4 Uni			
5 8	should be d					24e. Wes e	en eutopsy med?	24b. Were eutopsy find aveilabla prior to completion of caus of death?					
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page 2 should								1 🗆 Y	es 2/CRNo	1 Yes 2 No			
ertificete hes been sector, page 2 should	Be	25. Was case referred to medical axaminer?	Hospital: 1 □ Inpatien	2 □ ΕΒ/Γ	Outpatient 3	I DOA Ott	her:	eth (Check only o	ne)				
iffer this certificate has been superal director, page 2 should	To Be	axaminer?	Hospital: 1 ☐ Inpatieni 28a. Dete of Injury (Month, Dey		Outpatient 3 . Time of Injury	28c. Inju Wo	her: 4 Nursing I	eth (Check only or	ne)	(Specify)			
for: After this certificate has been s the funeral director, page 2 should	Certification: To Be	axaminer? 1 □ Yas 25□ No 27. Menner of Deeth 13□Maturel 5 □ Panding	28a. Dete of Injury (Month, Dey	Year) 28b.	Time of Injury	28c. Inju Wo	her: 4 Nursing I ny et rk?	eth (Check only or Home 52 Resid 28d. Describe h	ence 6 Other ow Injury occurred	(Specify)			
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State of Maryland / Department of Health and Mental Hygiene 9 9 10550

					Cei	rtificate	e of	Death			Reg. No.	W 1	0000
1			1. Decedent's Neme (First, Middle, Last)							2. Dete of De	eth	Lucer	3. Time of Death
	Physic		Raymond Wesley He	rshev						Month March	Dey 11 1	999	9:20 a.m
	/Medi Exami		4e. Fecility Neme (If not institution, give street en					4b. City, To		cation of Deeti		nty of Deeth	
	LAGITIII	ici	Moran Manor Nursing	Home				Wes	tern	port		Alleg	anv
1	Funeral		5. Sociel Security Number 6. Sex	7. Aga (In yrs. last	birthday)	If Under	1 Year			8. Date of Bir	th	1	npiece (Stete or Foreign
L	Funeral Director		234-48-2958 1M M 2C Usuel Residence of Decedent		Yrs.	Months	Days	Hours	Min.	(Month, De	1,1927	Cot	t Virginia
	land		10a. Steta 10b. County	10c. City, T	own or Lo	ocation							10d. Inside City Limits
	he Mery 28a-f sh	ector	WV Mineral		Keys					1			1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. them 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Experiment be notified as	Funeral Director	10e. Street end Number 77 Spring Street			10f. Zip					10g. Citizen o		untry?
0	after de	Fune	Arme	Decedant Ever In U.S. od Forces?	13.				gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	- 14. R	ace - Amer leck, White	rican Indian, a, etc.
005	ours a	by	3 ☐ Widowed 4 ☐ Divorced If Ye	(as 2□No s, Give Korean or Detes: Conflic	ct	1 ☐ Yes 2	. No	Specify:			Spec	ify: W	hite
21215-0020	n 72 h	Completed	15. Decedent's Education (Specify only highest grede comple	ted)	6a. Deced	dent's Usual	l Occup k done	petion during most	of worki	ng	16b. Kind of Animal		•
212	withii iene. than	dwo	Elementery/Secondary (0-12) Colle	ge (1-4or 5+)		cer/In						rator	
P	Hygi Hygi ent,		17. Fether's Neme (First, Middle, Last)				·ope		r's Neme	(First, Middle			J
Maryland	Vental Vental rked o	To Be	John W. Hershey						Mami	e Harma	ın		
lan	2 sho and h la ma		19a. Informent's Name/Relationship (Type, Print) 1	19b. Mailir	ng Address	(Stree	t end Numbe	er or Rure	I Route Numb	er, City or Tow	n, Stete, Z	ip Code)
	end ealth n 27		Twila L. Hershey/Wife					Street		Keyser,	WV 2	6726	
Baltimore,	permit. Pages 1 end Department of Health Important: If item 27 any Injury or other tr once.		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel 1 4 ☐ Donetion 5 ☐ Other (Specify)	rom Stete ceme	etery, crer	osition (Nem metory or ot Ceme	har ple		Ма	rch 14 1999	20c. Location		
Balti	permit. Pages 'Department of H Important: If ite any Injury or of once.		21. Signeture of Funeral Service Licensee	WI		2. Name and Rotr	Addre	ess of Facilit	h Fu	neral H	lome		
	_		23e. Part1. Enter the diseese, or complications to	het causad tha death. D	Do not ent			Main S			eyser,	WV 2	26726 Approximata
	Physician		shock, or heart failure. List only one ceuse	on each line.			,	,					Intervel Between Onset end Deeth
7	/Medical		Immediate Ceuse (Finel disease or condition As	spiration P	n a i i m a	onia						1	2 Weeks
	Examiner		resulting In death) e.	Due to (or es									Z WEEKS
-	₽ ≅	ner	CI	ronic Obst			ı 1 mc	narv	Dise	ase			20 years
	ecute and -trans	Examiner	0.	Due to (or es								1	
68760,	ficete be executed) physician and ss the burial-transit		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	herosclero	tic I	Heart	Dis	sease					10 years
387	phys the	Medical	that initiated events resulting In deeth) Lest	Due to (or as	a conseq	uence of):							
Box 6	n certific anding p use es	n/Me	d. Co	ongestive H	eart	Failu	ıre						10 years
	att att	Physician	Part II. Other eignificant conditions contributing	to death but not resulting	g in the u	ndertving ca	use di	ven in Pert I.		23b. Dld	tobacco use o	contribute	to the cause of death?
P.0		Phy	Co Ivace Condice Anni	arrehma a						1 🗆	Yes 2□ No	3 □ Pr	obably 4⊠ Unknown
	es the	þ	Ca Lung; Cardiac Arri	ту спшта									
Records,	law requires that as been signed b	Completed								24a. Was perfo	en eutopsy rmed?	a	Were eutopsy findings available prior to completion of cause of death?
	0 - 6	E								10	Yes 2X No	1	☐ Yes 2☐ No
Vital		Be C	25. Wes casa referred to medical					26. Piece	of Deeth	(Check only o			
t <	G is	5	exeminer? 1 ☐ Yes 2 ☒ No Hospital:	1 ☐ Inpatient 2 ☐ ER/	Outpatier	nt 3 DO	A Ot			ne 5 ☐ Resi		ther (Spec	cify)
on of	ing	1 1	27. Manner of Deeth 1 🖾 Neturel 5 🗆 Pending 2 🗀 Accident Investigation	Dete of Injury Month, Dey Year) 281	b. Time of Injury	f 28	Bc. Inju Wo		- 1	28d. Describe			
Division	or Attending after death. Diractor: After d in by the fune	Certification:	3 Sulcida 6 Could not be	Plece of Injury - At home, uilding, etc. (Specify)	, farm, str	eet, factory,				28f. Location (City or To		n <i>ber</i> o <i>r R</i> u	rel Route Numbar,
	oral paral p		00-0-0-0										
	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To 2 ☐ Medical Exeminer: On the end	o the best of my knowled ne besis of examinetion menner steted.	dge, deeth end/or inv	n occurred e vestigetlon,	in my	me, dete en opinion, deal	d plece, a th occurre	and due to the ed et the time,	ceuse(s) end a dete end place	nenner es a, end due	steted. to the ceuse(s)
	within 2 To the	Σ	29b. Signeture and title of cartifiar	٨.		29c.	Licans	sa number			29d. Date sign	ned (Month	n, Dey, Yaer)
	6		008	no	M.	1	D	40182			March	16, 1	999
	1411		30. Name end eddress of person who completed	7 1		,							
	126		Mahesh B. Shroff, M 31. Dete filed (Month, Dey, Year)	D. 390 C. Registrar's Signeture		adon I	Lane	2	Key	ser, W	267	26	
	Sta Registr	- 1	MAR 1.9 1999	2. Registrar's Signeture	4	A STATE OF THE PARTY OF THE PAR	1	,					

911 - 41

5 July 1995

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				and / Depa	artmer	nt of		and N			9	9	105	51
1. Decedent's Name (F	irst, Middle,	Last)							2. Dete of D	eeth Day	,	Year	3. Time o	of Death
Queen	Victo	oria H	udson						Mar.1		99	1001	9;50	AM
4a. Fecllity Neme (If no	t institution,	give street and nu	ım <i>ber</i>)				4b. City, To	wn, or L	ocation of Dea	th 4c.	County	of Deeth	1	
312 N.Du	lany	Avenue					Frui	tlar	nd	Wi	COL	mico		
5. Social Security Number 5. Social Security		5. Sex 1 ☐ M 2 KF	7. Age (In yr 86	rs. lest birthday) Yrs.	If Unde Months	Deys		24 Hrs. Min.	8. Dete of B (Month, D June	ey, Year)	91:	Cou	aplece (Stete	314711
Usual Residence of De	cedent													
10a. State 10 Maryland	b. County Wicc	omico		City, Town or Lo Fruitl									10d. Inside (City Limits s 2 ☐ No
10e. Street end Numbe	r				10f. Zi	p Code				10g. Citi	zen of \	Whet Cou	untry?	
312 N.Du	lany	Avenue			21	826				U.S	.A			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 1 Yes 3 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 5 1 Yes 6 1 Yes 7 1 Y					-	dent of ecify Cut			pecify Yes or N Rican, etc.)	0-		ck, White		

Funeral 11. Marital Status þ Completed

Be

2

Director

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Haalth and Mantal Hygiena. Important: If item 27 is marked other than "naturet", or items 23a or 28a-f show eny Injury or other traumatic event, the Modeal Experiment must be notified at once.

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

physician and the burial-transit usa as been signed by the attanding should be datached for usa as paga 2 s Hospital or Attending Physician: Tha 24 hours after death.
 Funeral Director: After this cartificate h funaral director, filled in by tha

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai þ Completed Be 10 Certification:

15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) Domestic None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) James H. Powell Lula Purnell 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 417 Overbrook Drive Salisbury, Md. 21801 James Hudson (Son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Ever Green Cemetery 1999 Berlin, Md. 22. Name end Address of Facility
Stewart Funeral Home 21. Signeture of Funeral Servica Licansee 821 West Rd.Salisbury, Md. 21801 23a. Part1. Enter the durease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fir ure. List only one ceuse on each line. Immediete Ceuse (Final Colon diseese or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1□ Yes VINo Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation Naturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Z Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner steted. 29b-Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Yeer)

Carroll St.

Solish, Mb 2150

State Registrar

complataly To the vithin 2

Medical

30. Name end eddress of person who completed cause of death-(Item 23e) (Type, Print)

145 E.

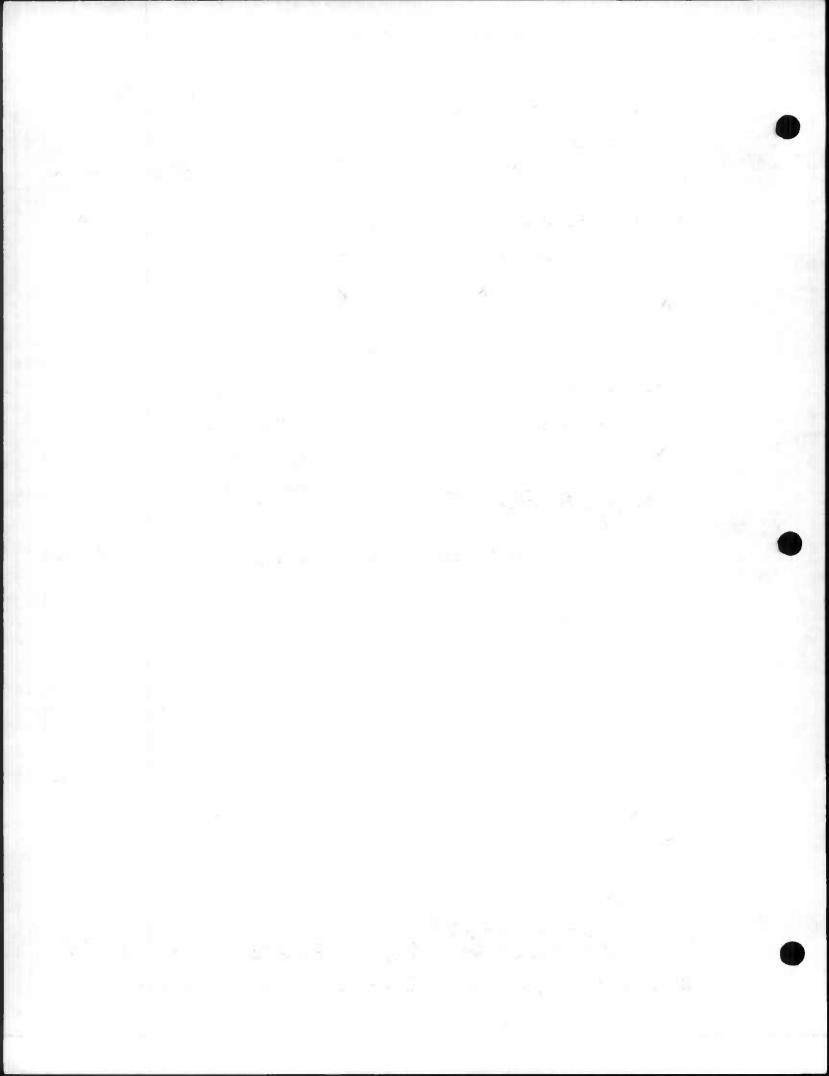
32. Registrar's Signature

Court MD

1999

31. Dete filed (Month, Day, Year)

MAR 18



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ANNA HOGARTH PEARSON 4:29 p.m. 1999 March 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F Yrs. 214-34-5082 98 Director August 21,1900 Delaware Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Maryland Worcester Ocean City 1⊠Yes 2□No Directo r than "neturel", or items 23a or 28a-f the Medical Exerviner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13601 N. Ocean Rd. 21842 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Specify: White þ 3 XWidowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude Pearson Mae Tigner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3817 Devonshire Dr., Salisbury, MD 21801 If them 27 is Patricia H. Bryan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Pages 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ö 3/13/99 Salisbury, MD Wicomico Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Sa Holloway Funeral Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List *only* one ceuse on each line. **Physician** /Medical Immediate Cause (Final ementia, Vascular Type disease or condition resulting in death) Examiner Examiner vase burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and certificate be axec Box 68760 physician Physician/Medical the SB use 0 Part I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco usa contribute to the cause of death? P.O. signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown py 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? paga 2 has 1 ☐ Yes 2 No 1 TYes 2 No certificata Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Netural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29e. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number negerio

State Registrar

31. Date filed (Month, Day, Year)

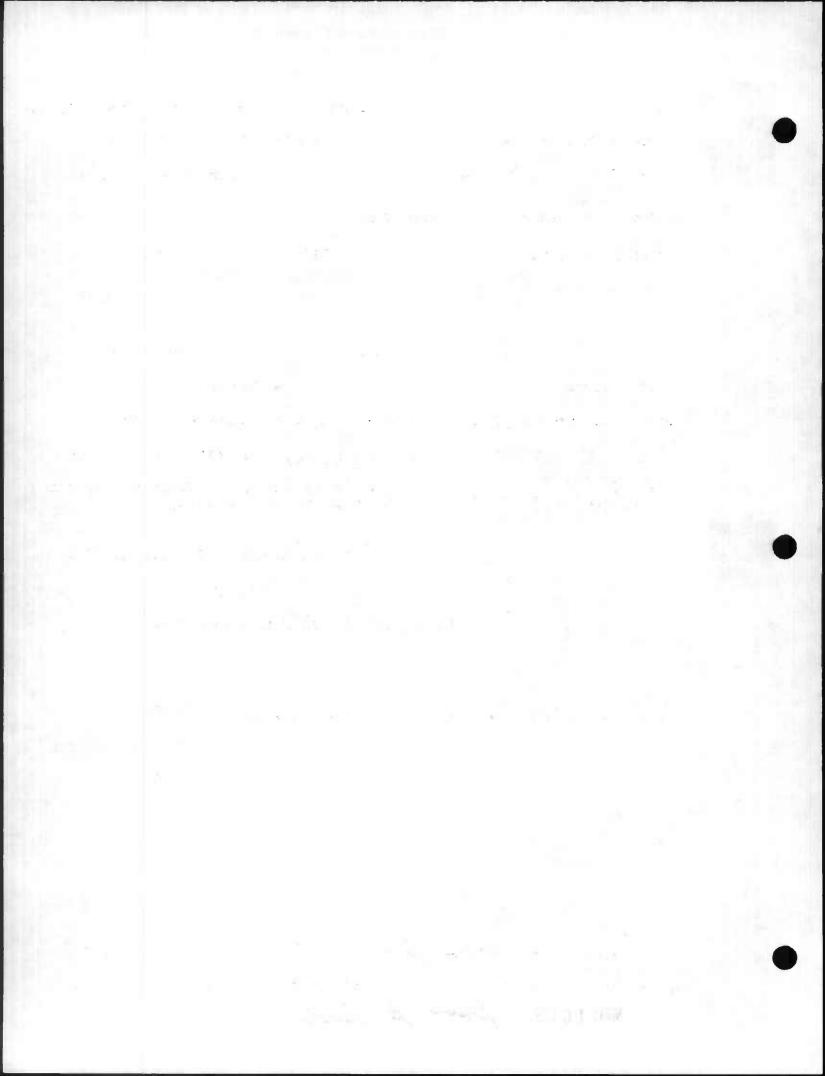
GREGORIO

MAR 1 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Lucy March 13, 1999 Hobbs 9:20 AM Marie /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Birthplaca (Stata or Foreign Country) **Funeral** Hours 1 □ M 200 F Months Days 97 July 17,1901 Director Maryland 220-12-0726 Usual Rasidanca of Deceden the Maryland 10e. Stata 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico 1 ☐ Yas 2X No Salisbury Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1302 Sylvia St. 21804 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. e filed within 72 hours after all Hygiene. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 X Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Domestic Homemaker 11 permit. Pages 1 and 2 should be file Deperment of Health and Mentel Hy, Important: If item 27 is marked othe any Injury or other traumatic avent, phos. 18. Mothar's Nema (First, Middla, Maiden Surnama) 17. Fathar's Nema (First, Middla, Last) Samuel T. Hobbs Ellen Maddox 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Eleanor McNeal/Niece 1300 Sylvia St., Salisbury, MD 21804 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 3/17/99 Parsonsburg, MD 4 □ Donation 5 □ Other (Specify) Parsonsburg Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting in deeth) /Medical Umas Examiner Due to (or as a consequence of) Physician/Medical Examiner the attending physician and hed for usa as the buriel-transit certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated evants Dua to (or as a consequanca of): Box 68760. can Dua to (or as a consequance of): resulting in death) Last signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 Probably 4 Unknown Records, by has been sig Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to completion of causa of death? performed? eßed 1 Yas 2 No 1 ☐ Yas 2 ☐ No cartificate Division of Vital Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpetient Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After this o 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending invastigation 1 PNatural Injury after death.

Director: Aft
d in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida hours after To the Hospital o within 24 hours af To the Funeral Di completaly filled in 1 Cortifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a, Cartifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian

State Registrar

DHMH 16 Rev 6/95

1104 Healthway DR.

Salisbury, MD 21804

30. Nama and addrass of parson who completed cause of deeth (Item 23e) (Type, Print)

M.D.

32. Registrar's Signatura

William H. Robins,

31. Data filed (Month, Day, Year) MAR 1 6 1999

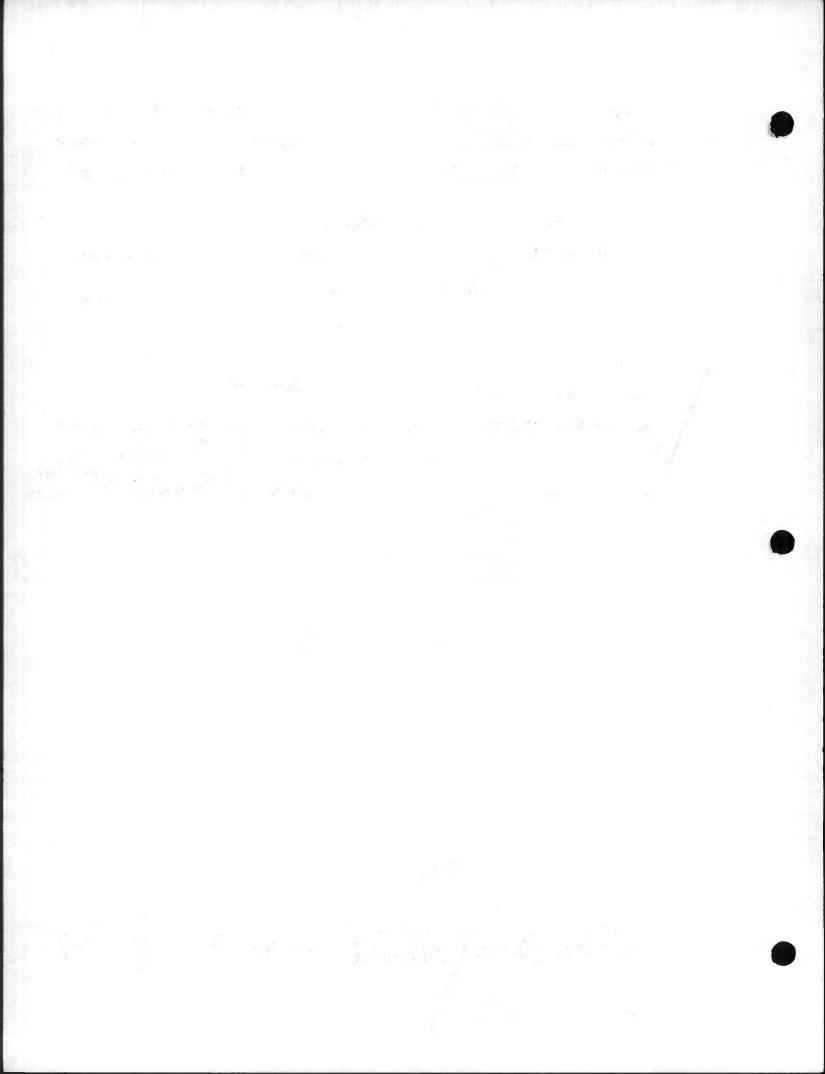
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) MARCH 19Pp 1999 0955 a.m HARFORD BETTY 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Deys 1 M 2 F 68 Yrs. June 14 1930 North Dakota 577 42 3725 Usuel Residence of Decedent 10c. City, Town or Location Port Republic 10d. inside City Limits 10e State 10b. County Calvert Maryland 1 ☐ Yes 2 XNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 20676 4191 Hance Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Sophie Bartok Hermen Peters 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 9938 Ferndale Ave. Columbia MD 21046 Melanie Waters- daughter Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other placeMarch 20 1999 4 Donestion 5 Other (Spacify) 20a. Method of Disposition 20c. Location - City or Town, State Alexandria Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address ot Facility 21. Signature of Funeral Service Licenses RAUSCH FUNERAL HOME, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 Approximete Intervel Between Onset end Death 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in deeth) Carliomyopathy unk Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence ot) Due to (or es e consequence of): 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings evellable prior to completion of ceuse ot deeth? 24a. Wes en autopsy performed? 1 Yes 202No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-4 show any injury or other traumatic evant, the Meulcal Examinet must be notified at once.

Baltimore, Maryland 21215-0020

ettending physician end for use as the buriel-transit signed by the e been sig page 2 s certificate hes

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

Hospital or Attending Physician:

To the Hospital within 24 hours of To the Funeral Completely filled

After this Director: After this in by the funeral death.

Physician/Medical Examine

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resulting in death) Last Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 25. Was case referred to medicel examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide

29a. Certifier

† Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

023468

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

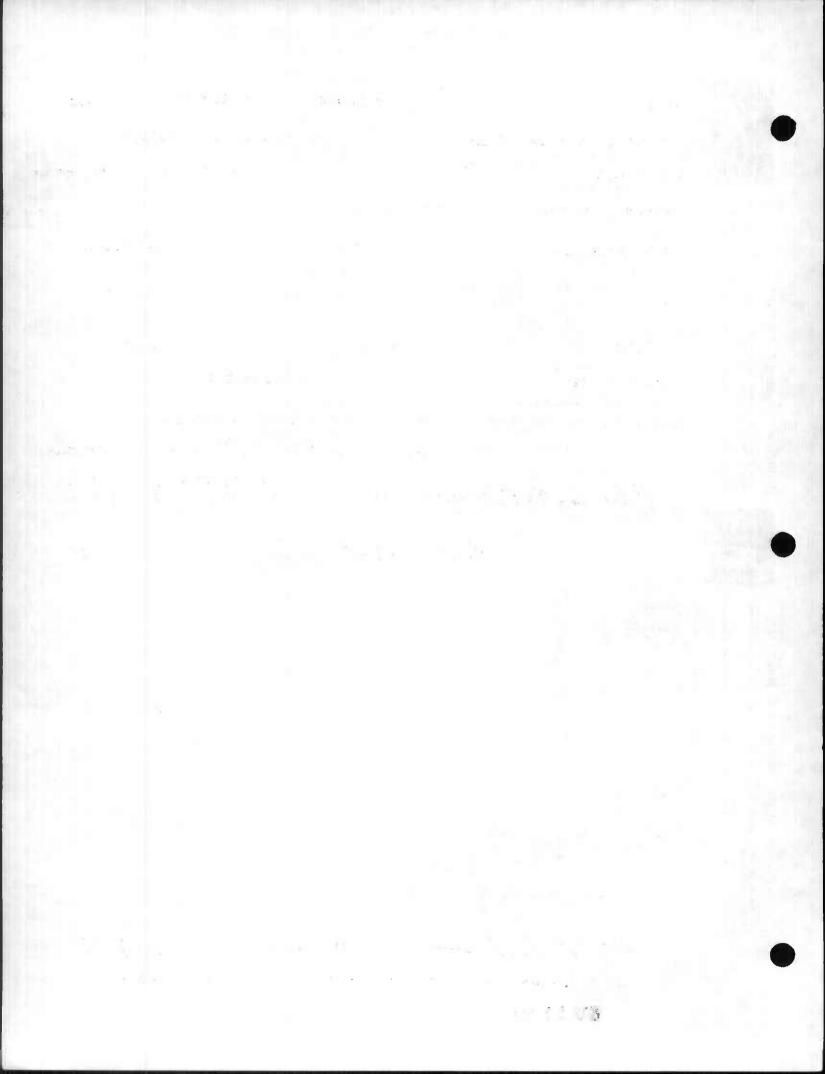
Prince Frederick, Maryland Kushner, M.D. Mark

20678

State Registra

31. Date tiled (Month, Dev. Year) 32. Registrar's Signeture MAR 2 3 1999





Certificate of Death

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Earl T. Harryman 4a Facility Name (If not institution, give street and number)

ARCH 4b. City, Town, or Location of Death

2. Date of Death

3. Time of Deeth 22, 1999 2:20 P.M

FRANKIN

5. Sociel Security Number SQUARE 1**X** M 2□ F 214-22-0742

7. Age (In yrs. last birthday) (en Tell 72

Deys

Rosedale Bal Timore

If Under 24 Hrs. B. Dete of Birth NOV. 19
Hours Min. Nov. 11, 1926 Maryland

4c. County of Death

Funeral Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 end 2 Depertment of Heelth e Important: If Item 27 Is

altimore.

AARVMA

10e. Stete MD

Director

Funeral

by

Be

Examiner

Physician/Medicai

Be

Medicai

10b. County Baltimore 10c. City, Town or Location Freeland

10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street and Number

Usual Residence of Decedent

1448 Freeland Rd.

10f. Zip Code 21053 10g. Citizen of What Country? U.S.A.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No It Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Rece - American Indian Black, White, etc. White

15. Decedent's Education
(Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pressman

16b. Kind of Business/Industry Newspapers

17. Father's Name (First, Middle, Last)

Elementery/Secondary (0-12)

Earl J. Harryman

18. Mother's Name (First, Middle, Meiden Sumame)

Constance Prevost

19a. Intormant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1448 Freeland Rd., Freeland, MD 21053

Carletta B. Harryman/Wife

20b. Place of Disposition (Name of

20c. Location - City or Town, State

20a. Method of Disposition

1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Cremation Service Date 1999

23a. Part1. Enter the disease, or composhock, or heart tellure. List only o

22. Name and Address of Facilit J.J. Harton . Hartenstein Mortuary, Inc. Second St., New Freedom, PA 17349 used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, in inc.

Physician /Medical Examiner

physician end s the bunal-trens

signed by the

or Attending Physician: efter deeth. Director: After this certifice

Hospital 24 hours e Funeral D

vithin 24 ho To the Fune

Rena FAILURE Due to (or as a consequenca ot):

24 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

tmmediate Cause (Final

disease or condition resulting in death)

ypolension Dua to (or as a consequenca ot)

Due to (or as a consequence ot)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Acute RespiRATORY FAILURE, STATUS POST

Colectomy secondary multiple polyposis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Was an autopsy

24b. Were autopsy tindings available prior to completion ot cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

with CAR Cinoma In-siTu 25. Was casa referred to medical examiner?

1 Yes 2 No

6 Could not be determined

5 Pending investigation

Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. tnjury at Work?

26. Place of Death (Check only one)

28d. Describe how Injury occurred

1 Yes 2 No 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) end menner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number

29b. Signeture and the of certifie

KD191825

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

DR. RITA MATHUR 9000 FRANKlin SPUARE DR. BALTIMORE, MARYLAND 21237 32. Regignar's Signature 31. Dete filed (Month, Dev. Year) Man 3

State Registrar

. 11 2 11 1 200 198 v - 65 - - 545 a multiple schart

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

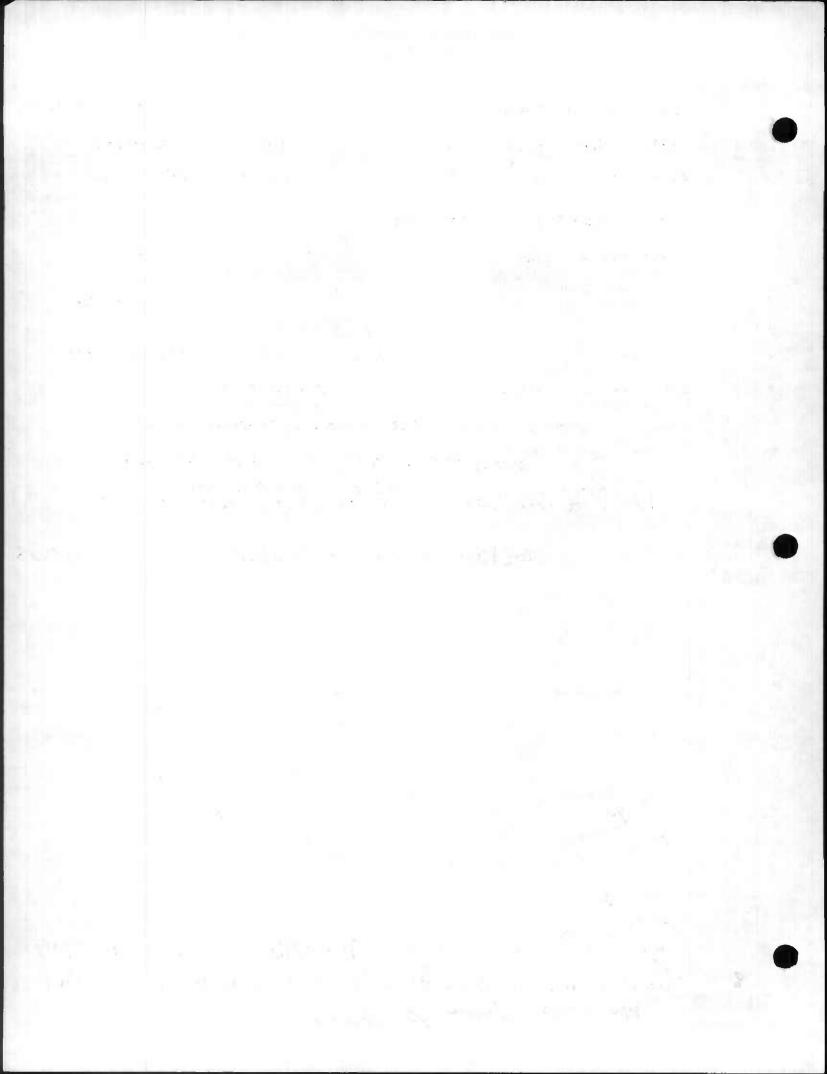
					C	ertificat	e of	Death		Re	g. No.			
F	Dhysia	ion	1. Decedent's Neme (First, Middle, L.	ast)					2	2. Dete of Deet Month		Yeer	3. Time	e of Death
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	Exami		4e. Fecility Neme (If not institution, gi NATIONAL NAVAL				4		vn, or Loce HESDA	ation of Deeth	4c. County MOI	of Deeth	ERY	
	Funeral Director			Sex 7. Ag 1.XXV 2□ F	96 (In yrs. lest birthde 96 Yrs.	Months	1 Yeer Deys	If Under 2 Hours	Min.	Dete of Birth (Month, Day, ept. 1,	Year) 1902	9. Birthp Coun Tex	iece (Stei try) (as	te or Foreign
	f show	or	10a. Stete 10b. County N/A N/A		10c. City, Town or Washi	Location ngton	DC					1		e City Limits
	the 1	Director	10e. Street end Number			10f. Zip				10	og. Citizen of \	Whet Coun	itry?	
	th with	O O	410 A Street SE					20003			U.S.		,.	
020	72 hours after deeth with the Meryland "natural", or Hams 23a or 28a-f show solicel Examiner must be notified at	by Funeral	11. Merital Stetus 1 ☐ Never Merried 2 ☐ Married XX Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 1 Yes 2 ☐ If Yes, Give Yeer or Detes:	No 1940-	3. Wes Dece If Yes, spe	dent of H cify Cuba		in? (Speci , Puerto Ri	ify Yes or No- can, etc.)	14. Red Bied	e - Americ ck, White,	etc.	l,
21215-0020	d within grene.	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 12	ducation ade completed) Coilege (1-4or 4	16a. De (Gi	cedent's Usu ive kind of wo a. DO NOT u b. Colo	rk done d se retired	during most ()		7	6b. Kind of B	GOVE		ent
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V a		To	Anthony Nicho	las Ivancio	ch			Cla	ara	Galena	Denn	У		
, Maryland	le m le m raum		19e. Informent'e Neme/Reletionship Mary Ellen Cymrot			-				Route Number, hingtor		. ,	Code)	
Baitimore,	Peges 1 end ment of Health ant: If Item 27 lury or other I		20e. Method of Disposition 1 ☐ Burlai 2 ☐ remetion 3 [4 ☐ Donetion 5 ☐ Other (Speci		20b. Piece of Discemetery, of Lee Cre	remetory or o	other plea		ch 17	,1999	Clinto			
Dall	permit. Peges Department of Important: If it any injury or once.		21. Signeture of Funerel Service Lice	nsee Bill	1001	22. Name er		ss of Fecility	L	ee Fune Ferry	ral Ho	me,]	Inc.	
	e Physician /Medical Examiner		23e. Pert1. Enter the disease, or conshock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in deeth)	e. PNEUM			le of dyln	g, such es c	cardiac or	respiretory erre	st,		Approxim Intervel I Onset an	mete Between nd Deeth
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09/90	eath certificete be executed ettending physician and for use es the burial-transit	sal Examiner												
00 X 00	ding phy nding phy use es the	n/Medical	resulting in death) Lest											
0.0	t the d by the teched	Physician	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute 1 Yes 2 \times No 3 Pert Pert											
ecords,	sw requires is been sign.	Completed by								24e. Wes er perform		cos	ere eutops eilable pri mpletion o death?	sy findings for to of cause
	The ate h	Con								1 □ Ye	s 211 No	10	Yes 2	2⊠ No
Alkal	ysician: The is certificate director, pag	Be	25. Wes case referred to medical examiner?	14			Lou		of Deeth (Check only one	9)			
5	5 00	70	1 ☐ Yes 2 ☐ No	Hospitei:				4 LI NUI		5 Reside			1)	
5	After fune	Certification:	27. Manner of Death 1 XNaturei 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ry 28b. Time y Year) Injur	y M	8c. Injury Worl	/ et <br Yes 2 □ N		d. Describe ho	w injury occur	red		
	Ital or At urs efter o ral Diraci lled in by		4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, fectory	, office		28	f. Location (Str City or Town,	eet and Numb , State)	er or Rura	l Route N	lumber,
	To the Hospital or Attano within 24 hours efter deet To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical Example (Check only one)	nysician: To the best on the basis of end menner sta	examination and/or	investigetion	, in my o	oinion, death	l plece, en h occurred	d due to the ca et the time, de	use(s) and me te end plece,	enner as st end due to	ated. the caus	:e(s)
	To T	Σ	29b. Signeture end title of certifier		1			number		29	d. Dete signe	d (Month, i	Dey, Year	r)
}			Hone 17	my my	2			54195		,	17-1	Mar	79	,
			30. Name and address of person who		_	-				MEDICA		ER		
	-04	40	ANNE T. FOX, I		NR // , ar's Signeture		DETH	ESDA I	MD 20	1889–560	JU			
	Sta Registr		0.00.00	1999 5	el s Signature	4	1	d.						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Physician 6:21 AM Jean Stanford Jester 03 1999 20 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Salisbury
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 30796 Johnson Road Wicomico If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1□M 21 F Yrs. Director 43 4/23/1955 214-60-8137 MD Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23s or 28s-f shore the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10a Street and Number 30769 Johnson Road 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Raca - American Indian, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4 or 5+) 12 courier Corporate Express 7 is marked other traumatic event, t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic eventualities. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira Russell Harshman 2 Margaret Matthews 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy S. Jester (spouse) 30796 Johnson Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 Dother (Specify) entantment Wicomico Memorial Park 3/27/99 Salisbury, MD 21. Signature of Funerel Servica Licansee 22. Name and Address of Facility Holloway Funeral Home, P.A. M01051 44. Poins Champson 501 Snow Hill Rd., Salisbury, MD 21804 23e. Pert1. Enter the disease, or complications I at caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreshock, or heart failure. List only one cause on each line. Approximete tritervat Between Onset and Death Physiclan /Medical Immediate Cause (Finel breast caneer years disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner physician end s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if sny, leeding to immediate causa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 80 signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobscco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? should 24e. Wes an eutopsy Completed is certificate has I 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Olrector: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours efter Funeral Dire letely filled in b Hospital Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29k. Signature 29c. License number 29d. Dete signed (Month, Day, Year) and title of cartifier MO. me and eddress of person who completed cause of death (Item 23a) (Type, Print) St Salisbury, md 21801 E/martin m.D E. 31. Date filed (Month, Day, Year) Registrar's Signature 32 State MAR 22 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0559

					, , , , , , , , , , , , , , , , , , , ,	Cer	tificate o	f Death)	R	eg. No.		10 30 2	
	Physic /Med		Decedent's Neme (First, Middle, L. James Norman							2. Dete of Dee Month March 1		9 Yeer	3. Time of Death 12:25 am	
	Exami		4a. Fecility Name (If not Institution, gi Southern Marylar			ter		4b. City, To		ocation of Death	4c. County	of Deeth	rge's	
	Funeral Director	_		Sax 7.	Age (In yrs. le	est birthdey) Yrs.	If Under 1 Ya Months Day		24 Hrs. Min.	8. Data of Birth (Month, Day Aug. 23	Year 932	9. Birthple Country Wash	ca (Stata or Foreign Engton, D	
	Maryland -f show	tor	Usuei Rasidenca of Decedent 10e. Stete 10b. County MD Prince 0	George's		Town or Lo	cation					100	d. Inside City Limits 1 ☐ Yes 2 No	
	h with tha 23a or 28a at be noti	Funeral Director	10e. Street end Number 6425 Livingstor	n Road			10f. Zip Code	745		1	0g. Citizen of USA	What Country	n	
020	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Health and Mental Hygiene. Important: I tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprenent must be notified at once.	by Funer	11. Merital Stetus 1 Navar Married 2 Married 3 Widowed 4 XDivorcad	12. Was Deceda Armed Forca 14 Yes 2 If Yes, Give Year or Dete	s?		Vas Decedent of Yas, specify C			pecify Yas or No- o Rican, etc.)		Rece - American Indien, Black, Whita, atc. Specify: white		
Maryland 21215-0020	within 72 ho ans. than "nature	Completed	15. Decedent's Elementery/Secondery (0-12)	Education rada completed) College (1-4c	or 5+)	(Give	ent's Usuel Occ kind of work doi OO NOT use ret clerk	ne durina mos	st of wor	king	16b. Kind ot B			
land 2	uid be filed Aental Hygie rked other tic event, ti	To Be Co	17. Fathar's Neme (First, Middle, Las Charles Blan	r	01017	18. Motho Mary		ne (First, Middle, I		me)	704			
, Mary	and 2 show ealth and N n 27 is men		19e. Intorment's Neme/Relationship Linda M. Walker/	8151	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8151 Simpson Farm Rd., Owings, MD 20736 ce of Disposition (Name of Dete 20c. Location - City or Town, Stete									
Baltimore,	Pages 1 thent of H tant: If her jury or off		20e. Method of Disposition 1 □ Burlal 2 □ Cremetion 3 [4 □ Donetion 5 □ Other (Special Content of the Conten	ify)	ce	ropoli	tan Cre	matory	i	Dete 3-14-99	20c. Location Alexan			
Ba	Departiment in the control of the co	L	21. Signature of Furtieral Services kiew	1/0	300	R		uneral	Hor	ne, Owi	_	2073	36	
	Physician /Medical	ľ	Immediete Cause (Finel	nplications that cads y one cause on aech			ar tha moda of o	lying, such as	cardiac	or raspiratory arr	est,	li li	Onset end Deeth	
	Examiner	Jer	disease or condition resulting in death)	е		as a conseq	uence of):					1	5 days one year	
,	icata be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Dua to (or	as a conseq		7						
x 68760,	E 04	Medical	Cause (Disease or Injury that initiated events resulting in deeth) Last C. RESPIRATORY FAILURE Dua to (or as a consequence of):											
P.O. Box	es that the death cer igned by the attendir be datached for use	/ Physician/M	Pert II. Other significant conditions						tribute to the cause of death?					
ecords, law requires th	been s	Completed by								24e. Was a perfor	n autopsy πed?	avell	e autopsy findings able prior to pletion of cause seth?	
talF	olcian: The law cartificata has rector, paga 2	Be Cor	25. Wes case refarred to medical					26 Place	e of Dec	1 ☐ Ya	Λ	10'	Yes 2□ No	
<u>></u>	5 00	To B	examiner? 1 ☐ Yes 24☑ No	Hospitei:	atlent 2 🗆 E	R/Outpatlen	3□ DOA	Other:		ome 5 Reside		har (Specify)		
Division of Vital	ding h. Afte fune		27. Menner of Deeth 11 Neturel 5 Pending 2 Accidant Investigation		njury Day Year)	28b. Time ot tnjury	28c. Ir V M 1	jury et vork? □ Yes 2 □	No	28d. Describe ho	ow injury occur	rred		
DIVI	frer d	Certification:	3 Sulcida 6 Could not l	ne, ferm, stre	eet, fectory, offic	e e		28f. Location (Si City or Town	treet end Num n, State)	nd Number or Rurel Route Number,)				
	Hospital or 24 hours afte Funeral Directly filled in	dical		hysician: To the beaminer: On the basis end manner	of exemineti									

6 1 VA

Bahram Redjaee, M.D.

31. Dete tiled (Month, Dey, Year)

32

MAR 1 8 1999

30. Neme end eddress of person who completed cause of death (Item 23a) (Typa, Print)

4467 Old Branch Ave., Temple Hills, MD 20748

1. Spark

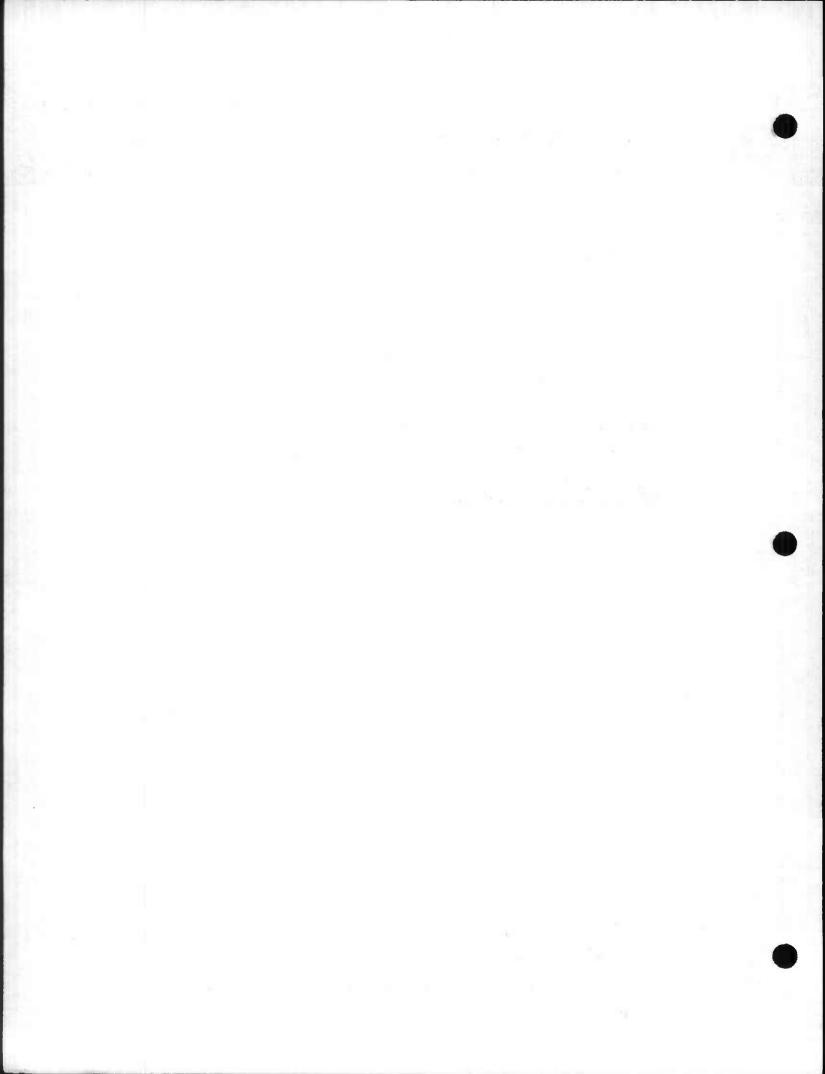
29c. License number

D 39691

29d. Data signed (Month, Day, Year)

March 13, 1999

State Registrar 29b. Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10560

							0	riunca	C OI	Dealli		Reg. No.				
		B	1. Decedent's Nan								2. Dete of D	Day Day	Year	3. Time of Death		
		Physician /Medical	No.	Ruth	Annie Wh	itesid	e Love				Marc		1999	0223		
4		Examiner	4e Facility Name	(If not institution	, give street and nu	mber)				4b. City, Town, or	Location of Dec	ath 4c. Count	y of Death			
		- LAGITITIES	На	rford M	emorial H	ospita	1			Havre d	le Grace	e	Harfo	rd		
	4-		5. Social Security		6. Sex		s. last birthda	(v) If Unde	r 1 Year	and the second second	-					
	- 1	Funeral Director	212-52-8080 1 M 2 X F 92 Yrs. Months Days Hours Mir									Day, Year) 13.1906		place (State or Foreign		
	1	Director	Usuel Residence	of Decedent							July	13,1700	Ten	nsylvania		
		Page 1	10a. Stata	10b. County		10c. C	City, Town or	Location					1	Od. Inside City Limits		
		r 28a-f ahow	Maryland		Cecil	111		p,	ort l	Deposit				1XXYes 2 No		
		vith the Me t or 28e-f a be notified	10e. Street and Nu		00011				Code	Deposit		10g. Citizen of	What Cou	ntn/2		
		the second	31 High					101. 23		21904			S.A.	noy r		
		s 23a	JI HIGH	DLIEEL	1.0.11						7 14 1			and the disco		
		flied within 72 hours effer death with the Maryland Hygiene. Hygiene than "natural", or ferma 23a or 28a-f ahow ent, the Medical Examiner must be notified at a Completed by Funeral Director	11. Marital Status		12. Was Dec	edent Ever in proes?	U,S. 13	If Yes, spe	cify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	14. Ha	ce - Americack, White,			
	20	A 2 1		rried 2 Merri	If Yas, Gi	VO		1 ☐ Yes	2X No	Specify:		Speci	fy: t.i	11-1-4-		
	5-0020	uraf,		4 Divorced	Year or D	ates:							W	hite		
	N.	ygiene. Ner then "neturn It, ma Wedgell Completed	(Spe	15. Decedent'	s Education t grade completed)		16a. Dec	edent's Usu re kind of wo	al Occup	pation during most of world)	rking	16b. Kind of 8	Business/In	dustry		
	2121	thin the	Elementery/Sec	condary (0-12)	College (1-4or 5+)	life.					D	1 0			
3		Hygier there	Six Ye					Hor	nemal					esidence		
a	Maryland		17. Father's Neme	(First, Middle, L	ast)					18. Mother's Nar	ne (First, Midd	le, Maiden Suma	me)			
	<u>a</u>	Menta Menta arked at Co.		Rober	t Whitesi		Annie 1	Nichols								
3	B 7	0	19a. Informant's N	leme/Ralationsh	nip (Type, Print)		19b. Ma	iling Addres	s (Street	and Number or Ru	rai Route Num	ber, City or Town	n, State, Zip	Code)		
U		TELB	Edwin L.	Thomas	(son-in-	law)	1562	Effo	rd R	oad, Pasa	dena,	Maryland	211	22		
	5	ーエミカ	20a. Method of Dis	sposition		20b.	Place of Dis	position (Na	me of	1	Dete	20c. Location		own, State		
	5	00-5		Cremetion 5 Other (Sp	3 Removel from		cemetary, cr Brookv				/19/00	Piging	Cun	Maryland		
1	Baltimore,	it but	21. Signature of F			-	-			ess of Fecility	0/10/99	KISING	sun,	rialyland		
,1999	Ba	permit. Pag Department Important: I any Injury o	21.00	C.	DIA					tterson &	Son F	uneral H	ome			
2			140	Too or	Marie	moon	S	Perry	ville	e, Maryla	and 219	03-0188				
5		_	23a. Pert1. Entar shock, or ha	the disease, or of art failure. List of	complications that conly one cause on e	caused the de ech line.	ath. Do not e	ntar tha mo	de of dyi	ng, such es cardia	or respiratory	arrest,		Approximete Intervel Between		
- 1		Physician							,		,		i	Onset end Deeth		
5		/Medical	Immediate Cause disease or conditi	ion	C_{ℓ}	ricdi	Vac	Divi	toin	AVV	rest			suth i		
reh		Examiner	resulting in deeth))	a	Due to	(or as a cons	equence of	TOY	/ 11	0.71		-	WITH		
65	0	الم الم			Sa	Spec	+ X	6011	-4	D.	0 0	0000	F	eu house		
21	1	an and riel-transit	Sequentially list of	onditions	b		(or as a cons	equence of)	011	or th	TEAM	2119	1	ca hours		
6	ó	E TOTAL	Sequentially list of if any, teading to it cause. Enter Und Cause (Disease of	mmediate leriving		1		1000								
	68760	ficate be physicia is the bur edical	Cause (Disease or injury that initialed events Due to (or es a consequence of):													
	89	certificate be executed nding physician and use as the buriel-transit n/Medical Examir	rasulting in death) Last													
2	X	nding use s			d		_						<u> </u>			
73	m	The law requires that the death cate has been signed by the atternance about be detached for Completed by Physicial	Part II Other elem	Mant condition	ns contributing to d	anth hut and make	anulting in the	dadisa	001100 ah	uon in Bort I	22h DI	d tobacco use o	ontribute t	o the cause of death?		
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0	5	7 00 0	1 ☐ Yes 2 ☐	No	Hospitel: 1	Inpatient 2	☐ ER/Outpati		UA		lome 5□Re	sidenca 6 □O	ther (Speci	ty)		
3		Ing Ph. After th funeral	27. Manner of Dea	ith 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time Injury	of	28c. Inju	ry at rk?	28d. Describ	e how injury occu	ırred			
0	0	Attending ir death. sctor: After by the fune	2 Accident	investig	etion			М		Yes 2□No						
1	Division	Arte ar de ector by th	3 Suicide 4 Homicida	6 ☐ Could n determin	ned 288. Place	of Injury - At	home, ferm, s	street, factor	ry, office			(Street end Nun	ber or Run	al Route Number,		
		al or A				ing, oto, (opot	,,									
		To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funers Medical Certification:	29e. Certifier (Check only		Physician: To the											
		he H he Fi piets	one)	Z medical E	end men	ner stated.	eadon and/or	ii ivesiigaiioi	ı, mı my c	opinion, death occu	med at the tim					
		To the Tour Common	29b. Signeture and	d title of certifier				29	c. Licens	se number	- 111	29d. Deta sign	ed (Month,	Dey, Year)		
				7/	ny		TID		1	19573		March	71	1999		
		5	30. Name and add	lrass of person v	vho completed caus	se of death (Ite	em 23a) (Type	e, Print)	C	1	7 . 1	- x 600	di	И /		
			MAN		M. LAZ	ATIN	1 .	D	8	Law S	olveel	1 Tree	arec	n Marylan		
		State	31. Date filed (Mor		32. F	legistrar's Sign	1 1	-				V	001			
	4	Registrar	MAR	1 7 1999	Ben	war	B. ,	door	6							

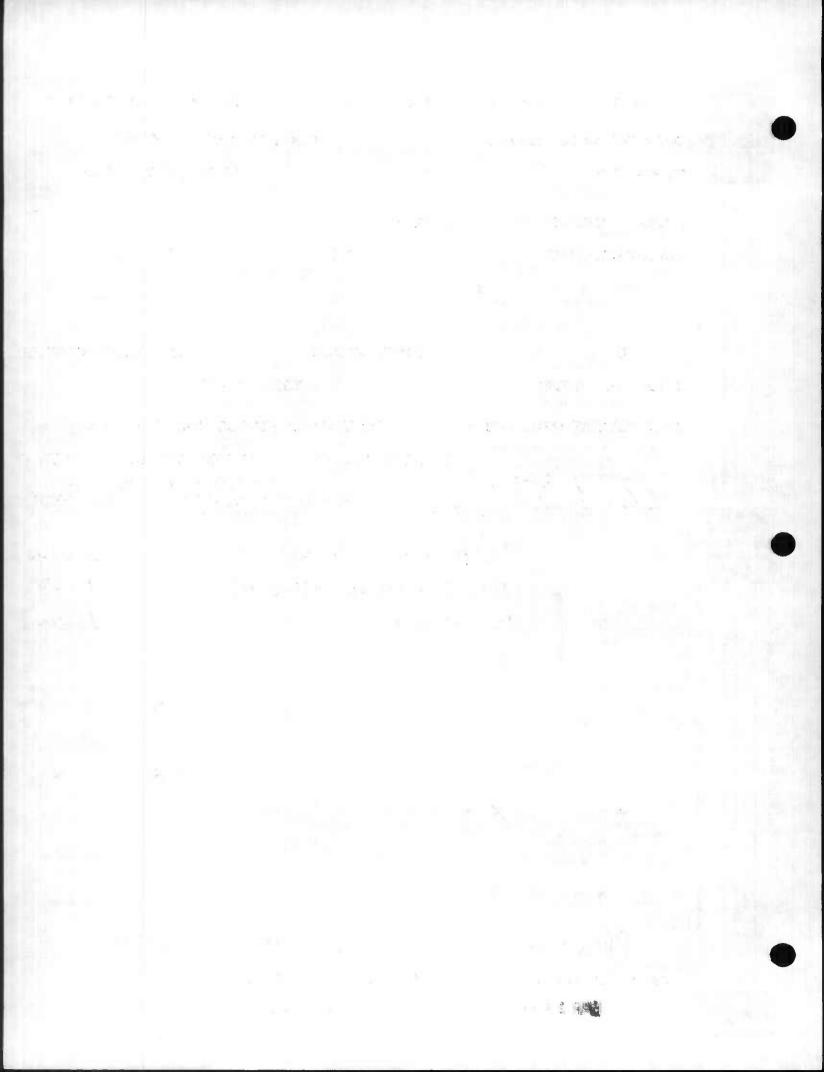
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State of Maryland / Department of Health and Mental Hygiene 9 1056

			Ce	rtificate of	Death	R	eg. No.	1 0	001		
	1. Decedent's Name (First, Middle, Last)					2. Dete of Dee	_	Vee	3. Time of Death		
Physician /Medical	JAMES HER	RBERT	LYONS	SR		MARCH	22, 1	999	0730		
Examiner	4e Fecility Neme (If not institution, give str	eet and number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth			
	CALVERT MEMORIAL HO	SPITAL			PRINCE FR	EDERICK	CALVE	RT			
Funeral Director	5. Sociel Security Number 6. Sex 212–14–8588 Usuel Residence of Decedent	7. Age (In yr.	s. last birthday) 86 Yrs.	Months Deys		8. Dete of Birth (Month, Dey JUNE 25		9. Birthpl Count MARY	ace (State or Foreign try) LAND		
pue *	10a. State 10b. County	10c. (City, Town or Lo	ocation				10	Od. Inside City Limits		
death with the Meryland wins 23s or 28s-f show criminal by notified at meral Director	MARYLAND CALVERT	80	LOMONS						1 ☐ Yes 2 ☐ No		
vith the Me.	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/het Coun	try?		
th wit	413 EPWORTH COURT			2068	38		U. S. A.				
P 2 2 2	1 Never Merried 2 Married	. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2√ No If Yes, Give		Was Decedent of It Yes, spacify Cult 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ben, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- America k, White, o	etc.		
d b	3 Widowed 4 Divorced	Year or Detes:					16b. Kind of Bu	WHI'			
	15. Decedent's Educa' (Specify only highest grade of Elementery/Secondary (0-12)		(Give	dent's Usuel Occu kind of work done DO NOT use retir	e during most of work	king	16b. Killd of Bu	SITIESS/ITIC	lustry		
	12		SERVI	CE MANAC					DEALERSHIP		
Be sent a	17. Fether's Neme (First, Middle, Last)				18. Mother's Nem		Maiden Sumem	e)			
Marylan d 2 should be th end Mental 7 Is marked o traumatic eve	JAMES P. LYONS	D (14)	400 84 10	A 44 (Ot	ELSIE	SWANN	- Charten	Ototo Zin	Code		
2005	19e. Informent's Neme/Relationship (Type	, Print)			et end Number or Ru						
C = W +	MARIE HARDESTY LYON:	S / WIFE	. Place of Disp	PWORTH Cosition (Name of	COURT SOLC	MONS, MA	RYLAND 20c. Location -	206 City or To	88_ wn, Stete		
0 80 2 2	1 Burial 2 ☐ Cremation 3 ☐ Ren		cemetery, cre	metory or other pi	ace) [V	ARCH					
Baltimo Permit. Pege Department of Important: If any injury or	4 Donetion 5 Other (Specify) 21 Signature of Funeral Service Licensee	MI		CEMETER 2. Name end Add		6,1999 I	KANDALLS	STOMIN	, MARYLAND		
Balt permit. Depertr Importa any Inju	MIK	TCI			LEE	FUNERAL					
	23a. Pary Enter the disease, or complica	tions that reused the de	81 Do not en	25 SOUTH	HERN MD BL	VD. OWIN	NGS, MAF	RYLAN	D 20736 Approximete		
Dhamisian	s work, or heart feilure. List only one	cause on each line.	DO HOU GO	ter the mode of dy	ring, such as cardiac	or respiretory en	031,	1	Intervel Between Onset and Deeth		
Physician /Medical	Immediete Ceuse (Finel disease or condition	RESPIR	KIONY	FA	ILUKE				2 days		
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58760, icete be executed physicien and s the buriel-trensit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	A	(or es e conse	quence ot):				į	1		
68760, flicete be ex physicien as the buriel	Cause (Disease or injury that initieted events resulting in death) Last C. ///////////////////////////////////										
O E E E	d										
	Pert II. Other eignificent conditions contri	buting to death but not re	esulting in the u	inderlying cause o	oiven in Pert i.	23b. Did to	obacco use cor	ntribute to	the cause of death?		
P.C. delthe delt						101	_		pably 4 Unknown		
S, F es that igned b be deter											
ord requir						24a. Wes e perfor		COL	ere eutopsy tindings eilable prior to mpletion of cause deeth?		
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r Vital Ko ystclan: The li s certificate he director, page fo Be Com	25. Wes case reterred to medical				26. Piece of Dee	th (Check only or	•		-		
Of VITA Physician: this certific ral director,	examiner? 1 ☐ Yes 2 No	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Whor	ome 5 Resid		er (Specify	1)		
on or ding Phys h. After this funeral di	27. Manner of Deeth 1 Natural 5 Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time o	1 28c. Inj	ury et ork?	28d. Describe h	ow Injury occurr	ed	1-7-7-11		
Attending or deeth. ector: After by the fune	2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Tes 2□No						
DIVISION I or Attending effer deeth. Director: Affer d in by the fune ertification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At building, etc. (Spe	home, ferm, st	reet, fectory, office	9	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
DIVISION O To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: Affer th completely filled in by the funeral Medical Certification: 7		ian: To the best of my ki									
the H the F tplete	one) 2 Madical Examine	end menner steted.	nation end/of if								
with To t	29b. Signeture end title of certifier				nse number	2	29d. Date signed	(Month,	Day, Year)		
	I Water me		-	D	50240		3/2	219	1		
~	30. Name end eddress of person who com										
10	PRANAY R PATEL,	M.D., PF	RINCE :	FREDERI	CK, MD 2	20678					

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3 Time of Death Month **Physician** McDermott atrick ohn March 1999 3:30 A.M. /Medical 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bohemia Lane Earleville If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Undar 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1 MM 2□ F Months 69 929 Pennsylvania 73 -22-92/3 Yrs. Director October 7, 1 Usual Residence of Decedent 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Ceci Maryland Earleville 1 ¥Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Bohemia Lane 21919 U.S. A death v Funeral Herrs : 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian Bleck, White, atc. filed within 72 hours efter 1 Nevar Married 2 Married 0. Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specity: white à If Yes, Give Yeer or Detes: 3 Midowed 4 Divorced "natural", Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Industrial owner-Star Industrial Inc. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Melden Surnema) permit. Pages 1 and 2 should be Department of Health and Mental Important. If New 27 Is marked or any Injury or other traumatic eve MCDermott Mary Jennings Cornelius P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Margaret E. Trendler, francee Earleville Maryland 21919 20b. Place of Disposition (Name of cametery, crematory or other place) Bohemia Lane 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremetlon 3 □ Removal from State March 22, St. Rose of Lima Cemetery Chesapeake City, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Andrew G. See Funeral Home 259 E. main St., Elkton, Maryland 21911 23a, Part1. Enter the shock, or heart edecime, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, failure. List only one cause on each line. Approximata Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel 7 months CANCER disease or condition resulting in death) Examiner Physician/Medical Examiner sician end buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. ettending physician for use es the burie Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown signed I Records, þ 24b. Wera eutopsy findings aveilable prior to completion of ceuse of death? Completed page 2 should 24a. Wes an eutopsy 1 ☐ Yas 2 € No. 1 ☐ Yes 2 No Division of Vital or Attending Physicien: funeral director, Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending Investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. Medical 29a. Certifier completely (Check only one) 29b. Signeture end title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Timothy
III W. High St #104 Elkton MO 219

32. Registrar's Signature

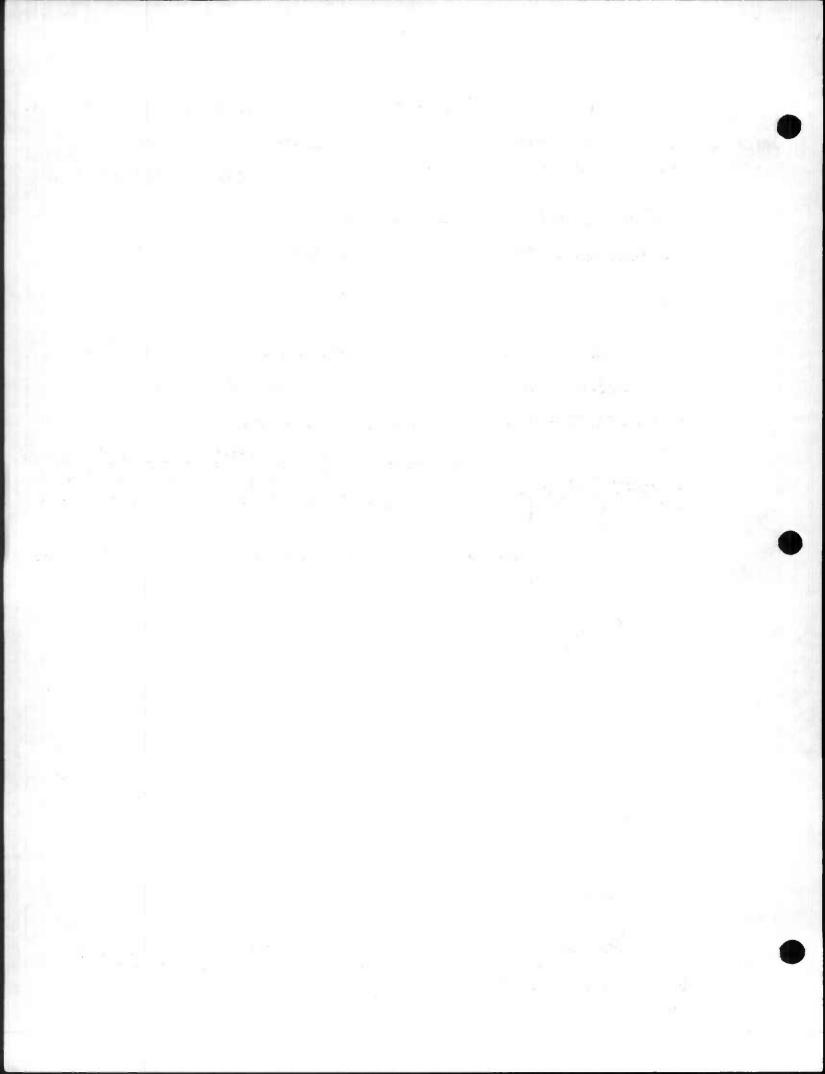
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State Registrar 31. Date filed (Month, DayWear)
MAR 2 2 1999

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Yee **PATRICIA** 16 1999 ISABEL MULLER-THYM 15:55 March 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Harford Memorial Hospital Havre de Grace Harford If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Social Security Number Days Months 1 ☐ M 2 🖾 F Yrs 73 June 22, 1925 180-24-2548 Ireland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Cecil Perryville 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 172 Muller-Thym Lane, Carpenter's Point 21903 United States 12. Wes Decedant Evar in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Maritai Stetus ☐ Yas 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) 12 Homemaker Her own Home 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Walter Wilkinson Sadie Stewart 19b, Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 172 Muller-Thym Lane, Carpenters Point P. O. Box 771, Perryville, MD 21903 19e. informent's Name/Reletionship (Type, Print) Lambert Muller-Thym / spouse Р. 20b. Pleca of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State March 17 West Chester cemetery, cremetory or other piece) 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stata 4 Donation 5 Other (Specify) 1999 R.A. Ferris Crematory Pennsylvania 21. Signature of Funeral Services License 22. Name end Address of Facility Crouch Funeral Home South Main Street, North East, MD 21901 Approximete interval Between Onset and Death 23a. Part1. Enler the disease, or complications that caused tha daath. Do not antar tha mode of dying, such es cardiac or respirelory errest, shock, or heert feilura. List only one ceusa on each line. Immediate Cause (Final disease or condition resulting in deeth) imones Sequentielly list conditions, if any, leading to immadiate causa. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting in death) Last Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 TNo 25. Wes case referred to medical axaminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

1 Yes 2 No

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year)

physician and the burial-transit the deeth certificate be executed 80 for use es ed by the deteched signed b r-Thym, Yastricia Isabel his certificate hes b Attending Physician: this funeral death

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at

7 is marked other traumatic event, i

or other t

permit. Page Department of Important: If any Injury or page.

Physician /Medical

Examiner

Examiner

Pages 1 and 2 should be inent of Health and Mental int: If item 27 is marked or

Directo

Funerai

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Completed

Be

filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

Physician/Medical 2 Completed Be 2 Certification: 1 Naturel 2 Accident 3 ☐ Suicide 4 Homicide

To the Hosp within 24 ho To the Fune completely fi Registrar

Director n 24 hours after dea ne Funeral Director inletely filled in by th

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2 Medical Examiner: On the basis of exeminetion end/or investigation, In my opinion, deeth occurred at the time, date end placa, end due to the cause(s) 29b. Sign

29a. Certifier

5 Pending

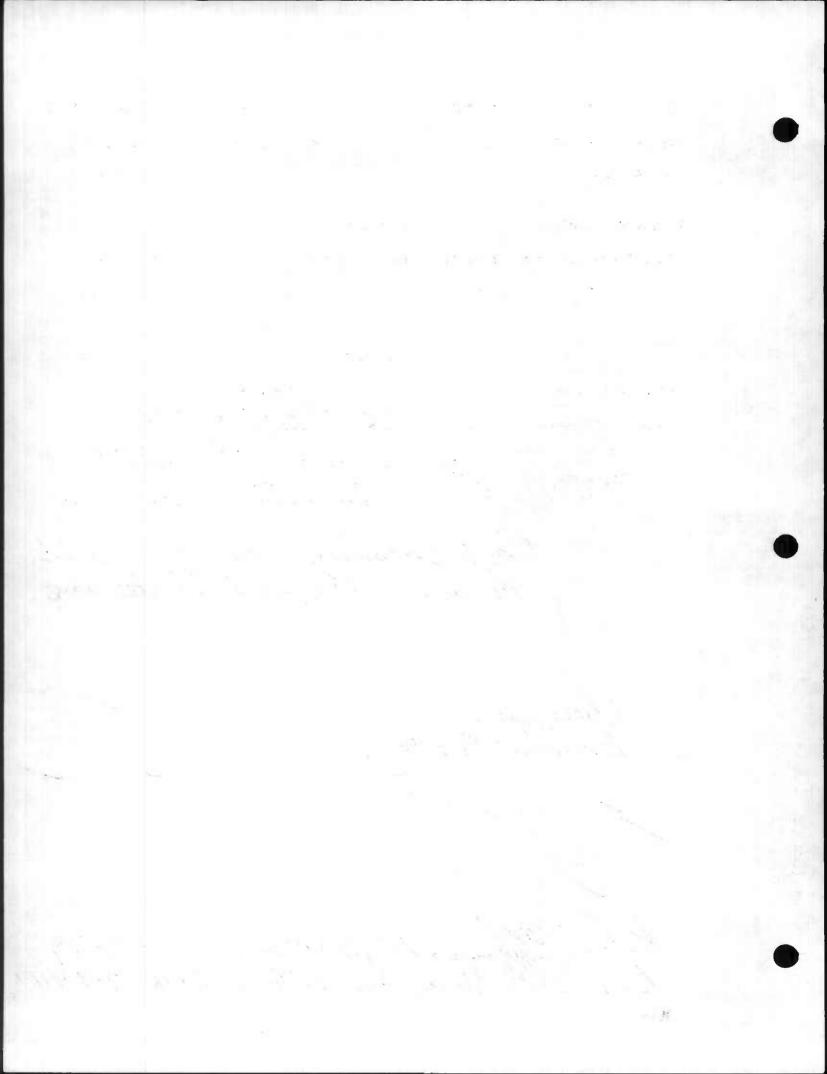
investigation

6 Could not ba

31. Date filed (Month, Dey, Year) State MAR 1 9 1999

death (item 23a) (Type; 32. Registrer's Signature

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Robert E. Mercer MARCH 18 1999 8:25 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany 8. Data of Birth (Month, Day, Year) Mar 11, 1 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 6. Sex 12 M 2□ F **Funeral** Months Days Hours Min 212-38-7187 55 Yrs. 1944 MD Director Usual Rasidance of Decedant with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits I is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MD Allegany 1 X Yas 2 □ No Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 301 Pennsylvania Avenue 21502 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Byss 2 □ No If Yes, Giva Yaar or Dates: 1961–64 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after onent of Health end Mental Hygiene.
Into if item 27 is marked other than "natural", or item ary or other traumatic event, the Medical Examples. 1 Navar Marriad 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade complated) College (1-4or 5+) Elemantary/Secondary (0-12) None N/A 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be Robert Paul Mercer Delphine (Myers) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Eleanor D. Reitmeier-sister 25 Race Street Cumberland MD 21502 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Department of important: If Cumberland Crematory 4 Donation 5 Other (Specify) 03/19 Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funaral Sarvica Licansee Cumberland MD 21502 plications that maked the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Ental tha diseasa, or complicate shock, or heart failure. List only one of Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) a. CARDIOPULMONARY ARREST unknown Examine Due to (or as a consequence of): Examiner PROBABLE THORACIC/ABDOMINAL ANEURYSM RUPTURE unknown physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting In death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): attending ph signed by the a d be datached f 23b. Did tobacco usa contributa to the causa of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown RESPIRATORY FAILURE þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of causa of death? certificata hes b 1 ☐ Yas 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director. 25. Was case rafarred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this funerel 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding invastigation after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

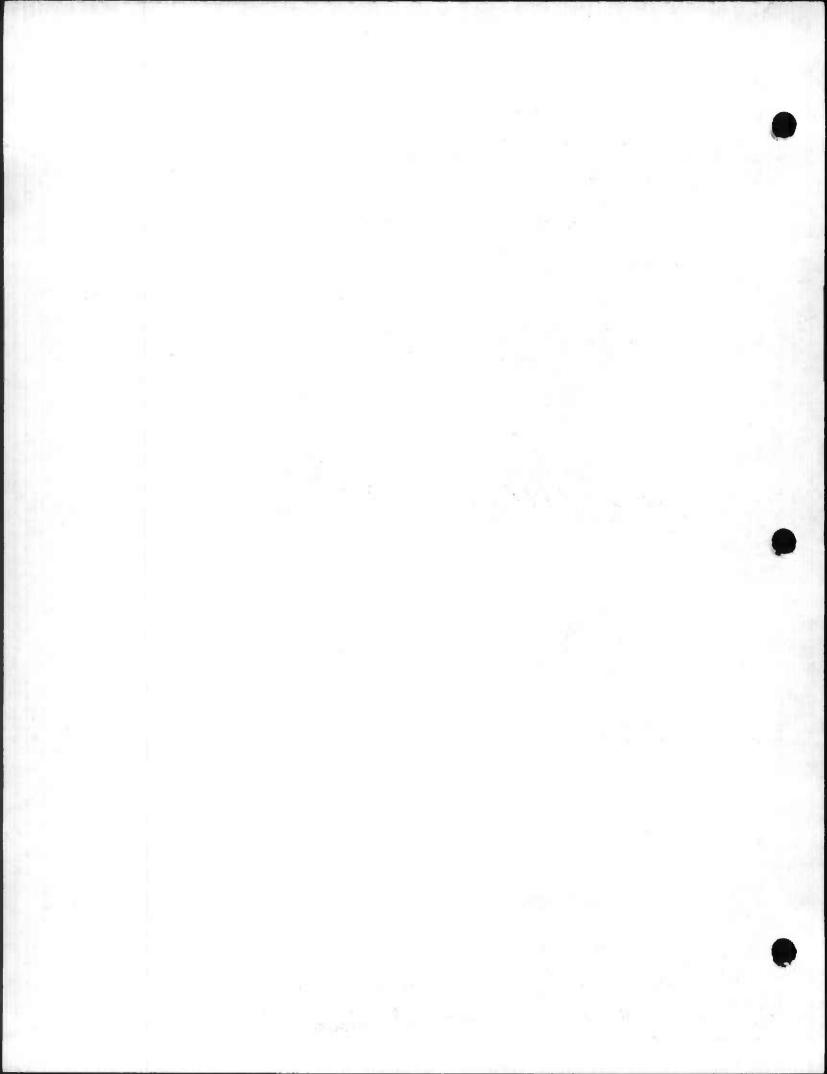
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai completely (Check only one) To the Within 2 Pulmonary/Cnitial 29c. Licansa number 29b. Signatura and titla of certifier 29d. Date signed (Month, Day, Year) MARCH 18 1999 (am redistre Hoo53855 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) This 900 SETON DRIVE CUMBERLAND MD 21502 STANLEY MATYASIK M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 1 9 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 10565

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-	Funeral		5. Social Security Number	6. Se		Age (In yrs.		thday) If Und	er 1 Yea	r If Under 24 Hrs.	8. Dete of Birth (Month, Dey,	Wicomic		(Stete or Foreign	-
	Director		215-36-1779 Usual Residence of Decedent	11	□M 2√F	91		Yrs. Months	Days	s Hours Min.	July 12,		Country)		
	wor.		10a. State 10b. Coun	ty	77779	10c. Ci	ty, Tow	n or Location					10d.	Inside City Limits	
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	efter death with the Meryler or Items 23a or 28a-f show iminal: mast be notified at	Funeral Director	11. Meritel Status		12. Was Decede Armed Force	ent Ever in U es?	ı,S.	13. Was Dec If Yes, sp	edent of ecify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rece - Black, ¹	American I White, etc.	ndien,	
21215-0020	urs in	2	1 Never Married 2 Me 3 Widowed 4 Divorce		1 Yes 2 If Yes, Give Year or Date	No es:		1□ Yes	XXN	Specify:		Specify:	Whit	.e	
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State of Maryland / Department of Health and Mental Hygienen

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Meares Naida Lockamy March 17, 1999 11:00 AM /Medical 4a. Facility Neme (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Mariner Health of Southern Maryland Prince George's Clinton If Undar 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number Birthplace (Steta or Foreign Country) 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** 1□M 2XF Deys Hours Director 579 26 0170 June 28,1925 Georgia Usuel Residence of Decedant the Merylend 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas MINO Clinton Director Maryland Prince George's 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? daath with 6708 Danford Drive 20735 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forces? 14. Race - American Indien, Bleck, Whita, atc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours altar o Department of Haelth and Mantal Hygiana. Important: if Item 27 is marked other than "natural", or Herr any Injury or other traumatic event, the Madael Exercises any Injury or other traumatic event, the Madael Exercises and 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) N A (1-4or 5+) Homemaker Home 18. Mothar's Nama (First, Middle, Melden Surneme)
Agnes Williams 17. Father's Neme (First, Middla, Last) Be Tommy Lockamy Agnes 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6708 Danford Drive Clinton, Maryland 20735 Robert L. Meares (Husband) 20b. Piece of Disposition (Name of March 25, Data 99) 20c. Location - City or Town, State Camatery, crametory or other piece)
Maryland Veterans Cemetery 20e. Method of Disposition 12 Buriel 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Seprios License 22. Nama and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, MD 20735 23a. Peril. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel IMC Aspiration Preumonia diseese or condition resulting in deeth) **Examiner** Due to (or as e consequence of): 2 ws Ceretor Vasculer Accident attending physician and for use as the burial-transit Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaese or injury that initieted events rasulting in death) Lest Due to (or as a consequence of): 4 Records, P.O. Box 68760. Ovam with metastan Carcinome The law requires that the death cartificeta be Physician/Medical Dua to (or as a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 2 1 Yes 200No 3 Probably 4 Unknown signed b þ cate has been significant category. 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed this cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wes casa referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28c. injury et Work? 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending 1 X Netural 1 Yas 2 No invastigation 2 Accident 3 Suicide 6 Could not be determined in by t 28e. Plece of injury - At homa, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours after To the Funeral Dir 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end mennar as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner steted. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 30. Neme and eddress of person who completed cause of deeth (item 23e) (Type, Print) 7501 Surratts Road #302 Clinton, Maryland 20735 Suresh A. Petal M.D.

State Registrar

MAR 1 9 1999

31. Dete filed (Month, Dev. Year)

32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Elmer Month Dav L. Murphy March 20, 1999 4:00AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9116 Dandelion Lane Upper Marlboro Prince George's 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 10XM 2□ F Deys Hours Yrs. 578-16-0190 Director June 19,1921 Maryland Usuel Residence of Decedent the Meryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 ☐ Yes 2 X No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20772 9116 Dandelion Lane U.S.A. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? 1942
1 XX 6s 2 No
If Yes, Give 1945
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 12 Manager Diamond Container Co 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be **Ambrose** Murphy, Anna Dickenson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9116 Dandelion Lane Upper Marlboro, MD 20772 Irene G. Murphy (Wife) 20e. Method of Disposition 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, Stete Date Resurrection Cemetery March 23 1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Maryland 1999 Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Pert1. Enter the disease, or complice shock, or heert feilure. List only one ons that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, ausaion each lina. **Physician** /Medical Immediete Ceuse (Finei diseese or condition resulting In daath) 51C Examiner Dua to (or es e consequence of) Examine ettending physician and for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immedieta cause. Entar Underlying Cause (Diseese or injury that Initieted events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ been si Completed 24b. Ware eutopsy findings 24e. Wes en eutopsy performed? avelleble prior to completion of ceuse of deeth? cartificate has N/A 1 Yes 20 No 1 🗆 Yes or Attending Physician: 25. Wes casa rafarred to medical examinar? Be 28. Piaca of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth 28c. Injury at Work? 28e. Dete of fnjury (Month, Day Year) 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 24 hours after of Funeral Direct letely filled in by 4 ☐ Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the causa(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piace, and due to the cause(s) within 24 hor To the Fune completely fi one) end manner steted. 29b. Signet nd title of certiling 29d. Date signed (Month, Dey, Year) 29c. License number March 22, 1999 30. Nente and addrass of person who complated cause of daeth (itam 23a) (Type, Print) 7801 Old Branch Ave. #409 Clinton, MD 20735 Michael Levine, M.D. 15+1 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Deneva books Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dev Vear March 18, 1999 6:00 AM IRENE Nicholson Nellie 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Salisbury, Salisbury Center: Genesis ElderCare MD Wicomico 8. Date of Birth (Month, Day, Year) AUG. 31, 1899 If Under 1 Year If Under 24 Hrs. Months Devs Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys 1□M 2K)F 99 220-28-4496 \$ALIS., MARYLAND Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 No MARYLAND WICOMICO SALISBURY 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? 515 DYKES 21804 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 TEACHER PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) SAMUEL MARSHALL IRENA WASHBURN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) FRANCES I. TONGUE - DAUGHTER 515 DYKES RD. SALISBURY, MD 21804 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-22-99 SALISBURY, MD PARSONS CEMETERY 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. BOUNDS FUNERAL HOME, INC. SA 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SALISBURY, 21804 MD Approximete Intervel Between Onset and Death Immediete Cause (Final diseese or condition resulting in death) con Due to (or es a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause ot death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Heelih and Menlei Hygiena. Important: If Item 27 is marked other than "natural" — any Injury or other treuments even.

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physician end the burial-transit The law requires that the death certificate be executed signed b page 2 s or Attending Physician: this n 24 hours after death.

he Funeral Director: After pletaly filled in by the fur

P.O. Box 68760 Division of Vital Records,

To the Hosp within 24 hos To the Fune completely fi

State Registrar

Physician/Medical þ Completed 25. Was case reterred to medical exeminer? Be Certification: To Medical

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Hospitel:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 29349

28c. Injury et Work?

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

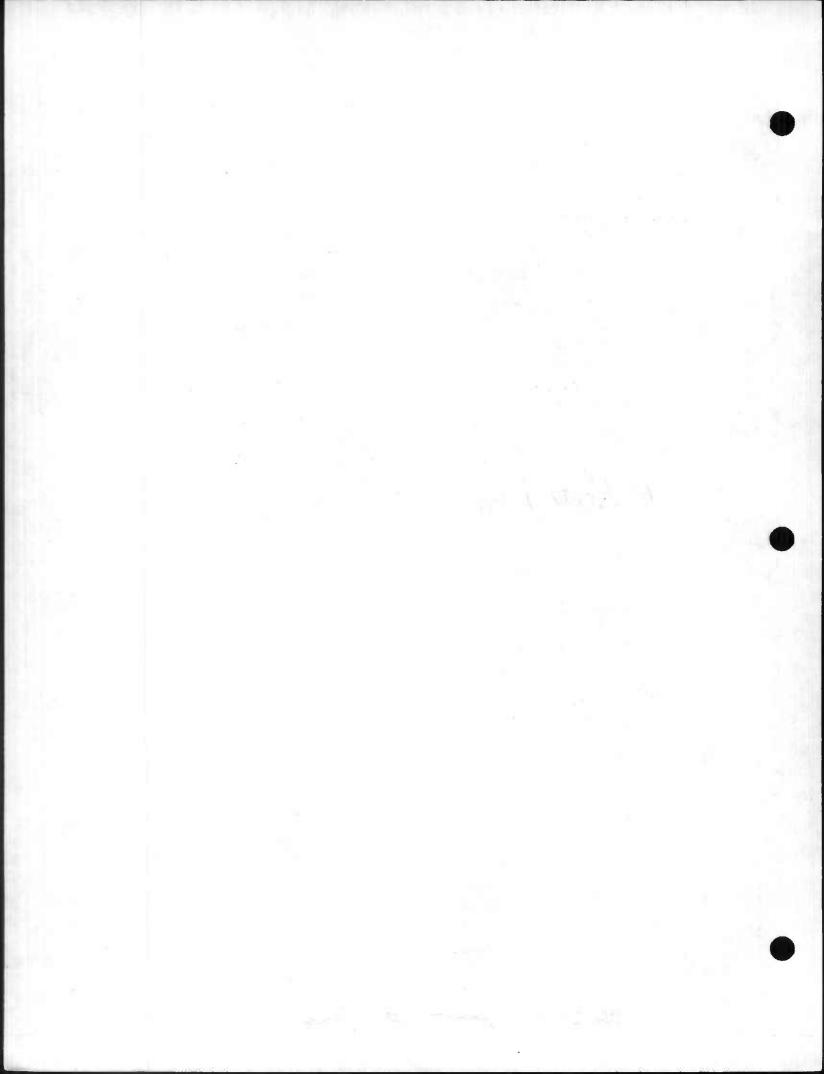
28t. Location (Street end Number or Rurel Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1104 Healthway Dr., Salisbury, MD 21804 William H. Robins, M.D.

31. Date filed (Month, Day, Year) MAR 1 9 1999 32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yaer 20 1999 4c. County of Deeth Preston McFadden March cation of Deeth Nock 4b. City, Town, or Loca 06:35 PM 4a Facility Nama (If not institution, giva street and number) Salisbury 800 Hanover Street If Undar 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplece (Stete or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) 10 M 20 F Months Deys Yrs. 220-12-1730 February 4, 1924 Salisbury, MD Usuel Residence of Deceden 10d. inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Hanover Street 21801 USA 14. Race - American Indien, 12. Was Decedant Evar in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Detes: ₩₩ ፲] Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specity: Specify: White 3 Widowed 4 Divorced WW II 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Plant Supervisor 5 Dresser Industries 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Thomas Nock Clara Edna Parker 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Rydia P. Nock/ Wife 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other place) Salisbury MD 21801 20c. Cocation - City or Town, Stata 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) Salisbury Crematory 3/22/99 Salisbury, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility M0/051 Holloway Funeral Home, Professional Association Snow Hill Road, Salisbury, MD 21804 Approximete Intervel Between Onset end Death anto DWGGA. 23a. Part . Enter the disease, or complications that caused the death. Do not enter tha moda shock, or heart failure. List only one cause on each line. nostate Immediate Ceuse (Final disease or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): Dua to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)

Physician /Medical Examiner physician and the burial-transit that the daeth certificate be executed

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ant: If item 27 is marked other than "natural; or items 23s or 28s-f show ury or other traumetic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

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7. Manner of Deeth	28e. Date of Injury (Month, Dey Yea		28	

5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Bc. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe)

28d. Describe how Injury occurred

(Check only one) 290. Signature end title of certifier

4 ☐ Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

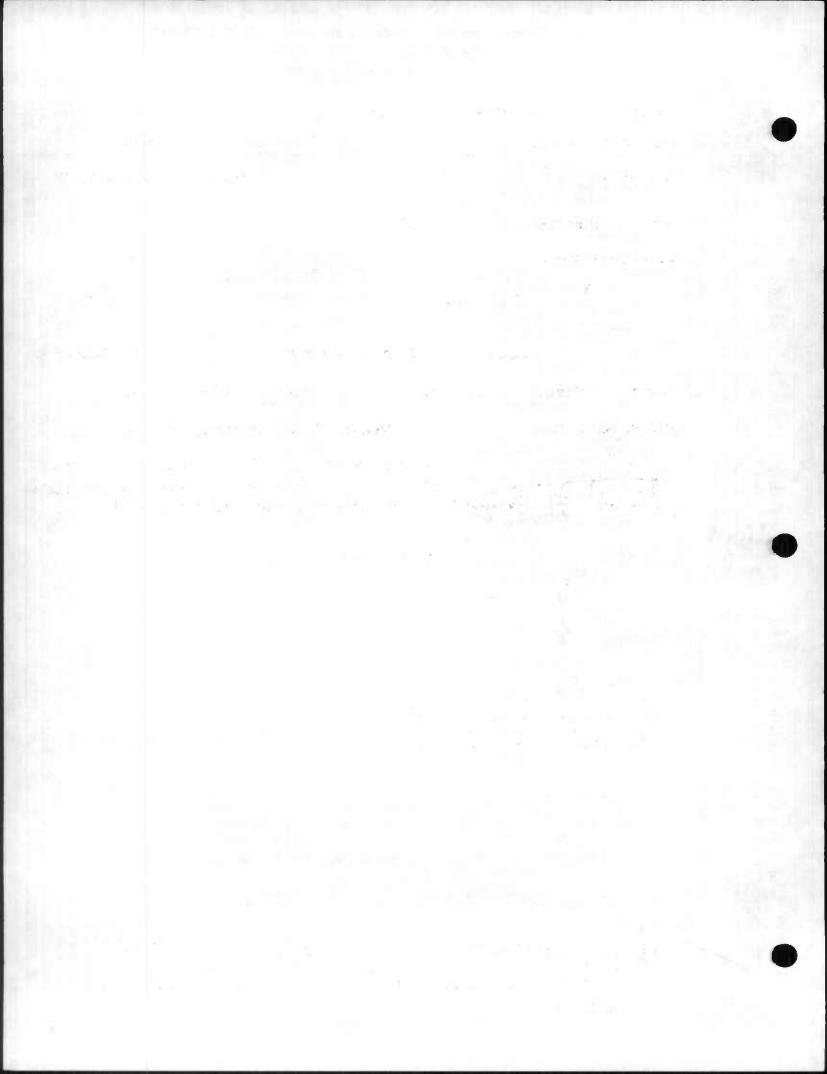
nd address of person who completed ceuse of deeth (Item 23e) (Type, Print) even 0

Kay Ave Salisbury

State Registrar

MAR 22 1999 31. Dete filed (Month,

32. Registrar's Signetura



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Data of Daath 3. Tima of Daath 1. Decedant's Nama (First, Middla, Last) Day Month **Physician** 1999 SUE ELLEN PARDEE March /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 119 East Main St. Ceci1 Cecilton Property If Under 1 Year | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplece (Stata or Foraign Country) **Funeral** Days Months Hours 1 □ M 2 1 F 219-42-5994 53 Yrs **Director** NOV 30 1945 Pennsylvania Usuel Residence of Decedant the Meryland 10c. City, Town or Location 10d. fnsida City Limits 10a. Steta 10b. County "natural", or Items 23s or 28s-1 show adical Examiner must be notified at 1 Yes 2 No Director MD Ceci1 Cecilton . 10a Street and Number 10f Zio Coda 10g. Citizan of What Country? WITH 119 East Main St. 21913 U.S.A. death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, 11. Maritel Status Black White etc. Pages 1 and 2 should be filed within 72 hours after of the filed and Mental Hygiena.
It is narked other than "natural", or its my or other traumatic event, the Medical Examinar 1 Navar Marriad Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) Office Manager Medica1 17 Fethar's Neme (First Middle Last) 18. Mother's Nama (First, Middla, Meidan Sumeme) Be Allan Ward Bailey Thelma Mae Wallace 19a. Informent's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) James Pardee Sr. (husband) Box 422 Cecilton, MD. 21913 item 2. 20b. Placa of Disposition (Nema of cematary, cramatory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/25/99 Cecilton, MD. 22. Nama and Addrass of Facility 21. Signature of Funeral Se Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. 21635 in the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, rearrialiura. List only one ceusa on each line. Approximete Intarval Betwaan Onsat and Daeth **Physician** /Medical Immediata Ceuse (Final hypertension YECUS disaasa or conditior resulting in death) Examiner Dua to (or as a consaquance of): Examiner obesity upours physician end s the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laeding to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ettending pl for use as 1 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilable prior to 24e. Was an autopsy Completed completion of cause of daeth? s certificate has b director, pege 2 s 1 Yes 2 No 1 ☐ Yas 2 ♥ No Hospital or Attending Physician: 24 hours eftar death. Funeral Director: After this certifice director Be 25. Wes case referred to medical axaminar? 26. Placa of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2□ No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data of injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1. Natural
2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 2 4 - Homicida To the Hospital or within 24 hours eft To the Funeral Dil completely filled in 29a, Certifian 1 Certifying Physician: To the best of my knowladge, death occurred at the time, data and place, and dua to the cause(s) and menner as stated. Medical Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licensa number march 21, 1999 D0051635 15 no complated causa of daath (Itam 23a) (Type, Print) - 100 Bawst Stephobale Hospital CHEGA MD union

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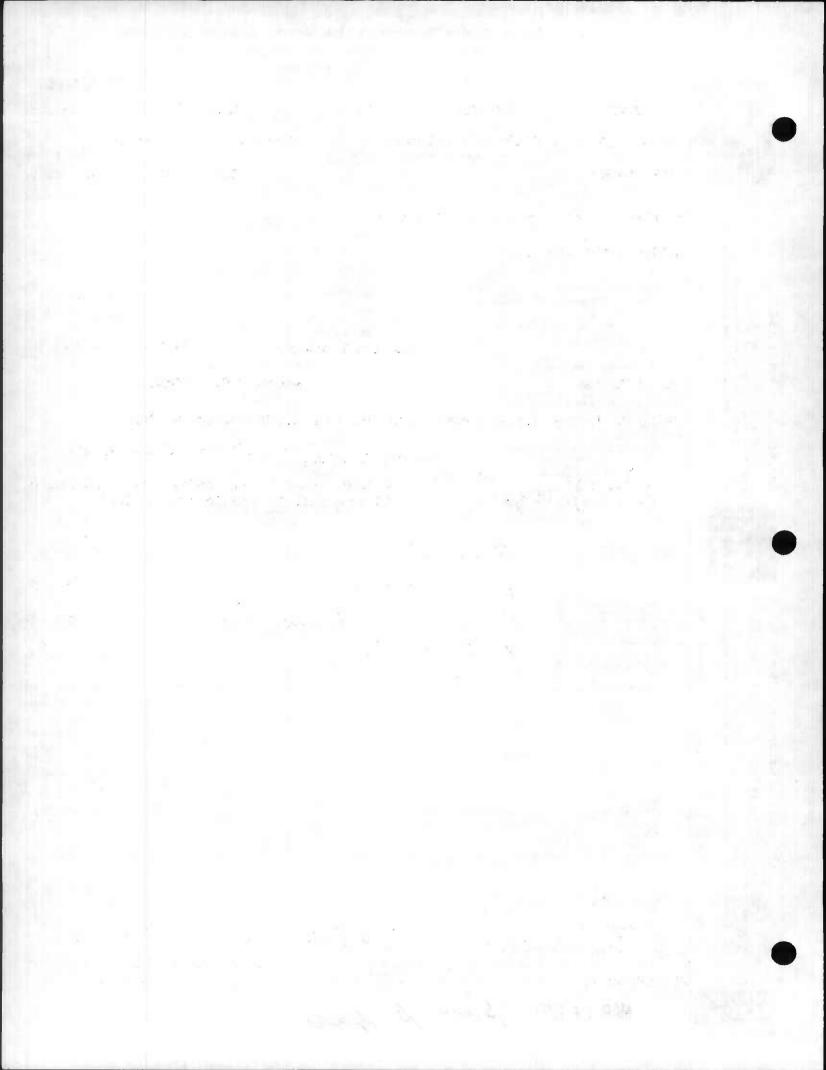
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or Attendant after dant Director:	E I	3 Suicide 6 Could no 4 Homlcida datarmin	ed Zoa. Flaca of I	njury - At ho		, streat, fact	tory, offica		2	8f. Location (S City or Town		ber or Run	al Route Number,		
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To the Hospital or At within 24 hours aftar of the Funeral Direct complataly filled in by	Σ	29b. Signature and title of centifiar		,		7	29c. Licens	se number	1/	9 2	9d. Data signe	d (Month,	Day, Year)		
		11/1/1/1/	Mul	-	~	2	1	XX	16	(3//	8/9	7.1		
	1	SQ. Name and address of person w	ho completed cause of	deeth (Item	23e) (Ty	pe, Print)			120	9 0	CENT	11	+16HerAR		
10		NICHOLAS	N. B.	DRO	oui	LIA	und) 3	FEA	Wick	476	ANI	OPE		
CAS		31. Data filed (Month, Day, Yaar)	32. Regis	trar's Signa	ture	7			270			,, 0,	-)		
Stat Registra	_		999	ww	1	4	/	4							



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 11, 1999
pocation of Death 4c. County of Death Verna Percival 8:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2₩ F Months Days Hours Yrs. 92 Pennsylvania Director 218-01-6810 January 19,1907 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1⊈ Yes 2 No Wicomico Salisbury Director Maryland 'natural', or hama 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21804 5679 Kingsmill Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiens important if filem 27 is medical. Elementery/Secondary (0-12) College (1-4or 5+) Beauty Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Cora Frances Bender James S. Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5679 Kingsmill Dr., Salisbury, MD 21801 James M. Beatty SR./Grandson 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury, MD 3/12/99 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) ture of Juneral Service Licens 22. Name and Address of Fecility Rolloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 27a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediale Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner dec physician and s the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown signed b Records. þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy parlormed? Completed has 1 Yes 2 HNO 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. after death Director: A 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 29349 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

William H. Robins, M.D.

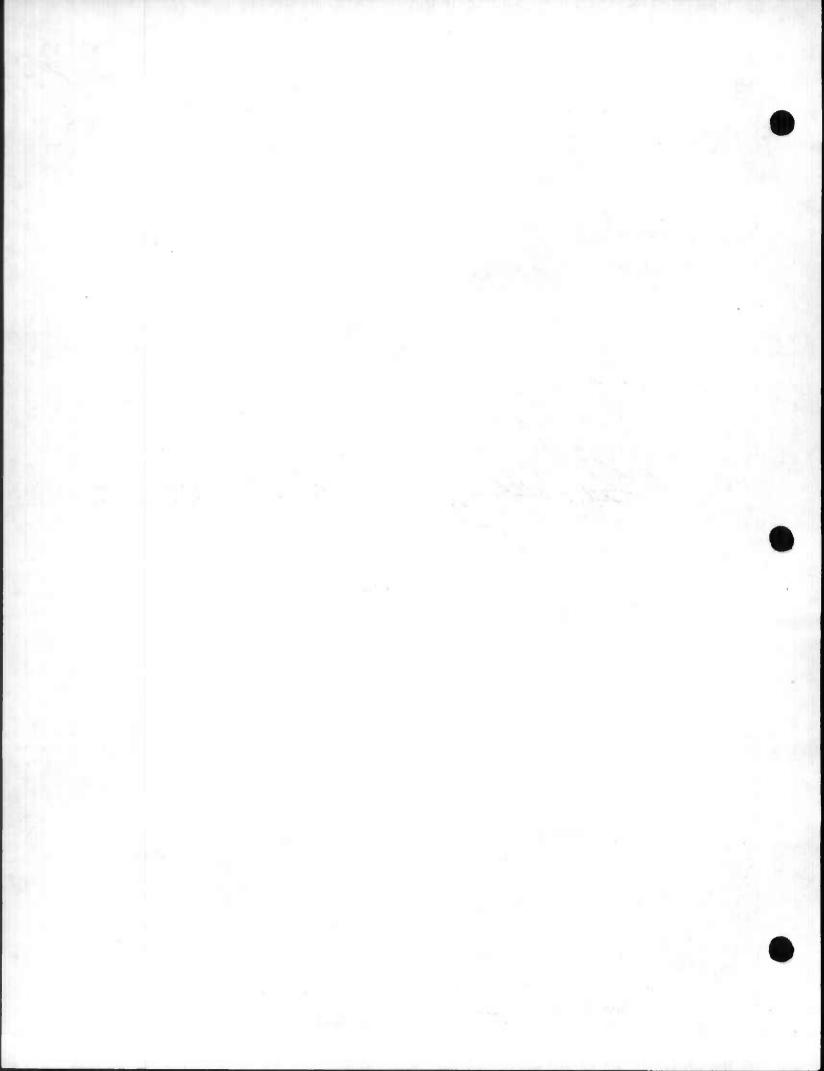
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DHMH 16 Rev 6/95

32. Registrar's Signature

1104 Healthway Dr. Salisbury, MD



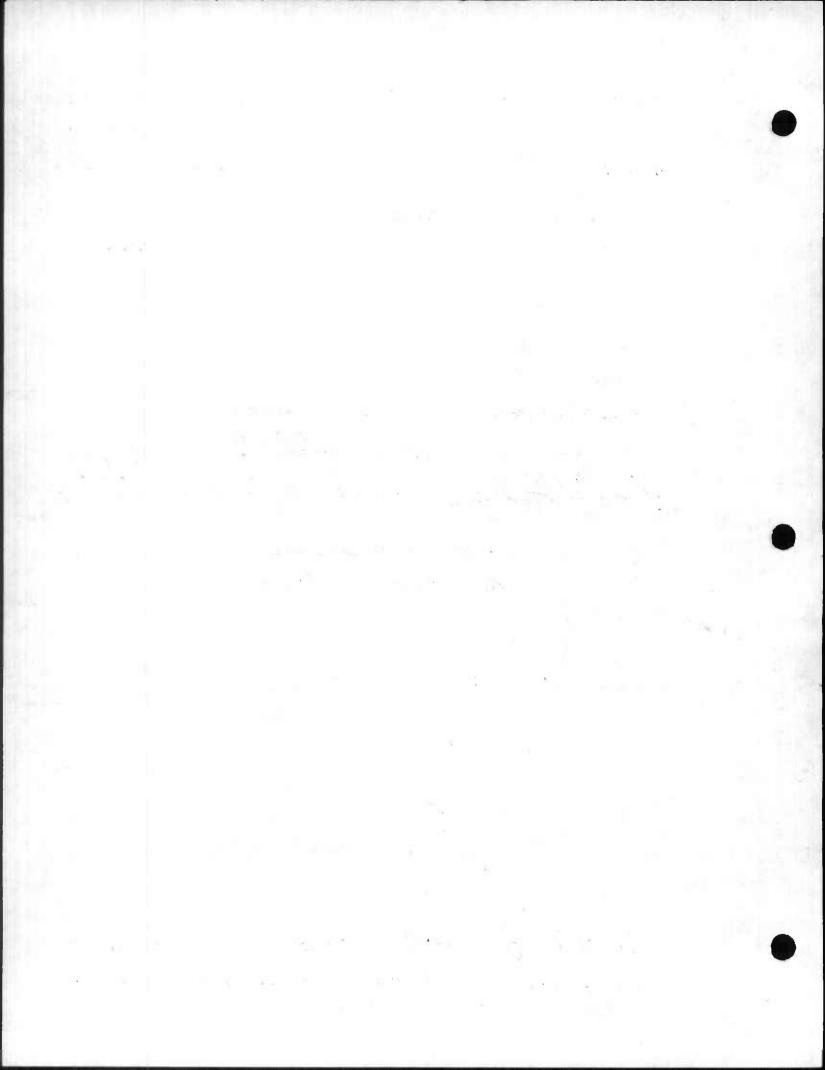
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 1 5 7 3

				Certifica	te of Deatl	ጎ	Reg. No.	10010			
	1. Decedent's Name (First, Middle, Le	ist)				2. Date	of Death	3. Tima of Death			
Physician /Medical	JONATHAN	ANDREW		PRAND	Y	Ma	rch 12,	1999 19:00			
Examiner	4a Facility Nama (If not institution, given	a street and number)		1 1		own, or Location of	Death 4c. Count	y of Death			
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Funeral Director	N/A	Sax 7. Aga 11⊋M 2□ F	(In yrs. last b	Yrs. If Und Month			of Birth th, Day, Year) Dary 17,1999	Birthplace (Stata or Foreign Country) Maryland			
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with the Ma	10e. Street and Number		DULL	-	ip Coda		10g. Citizan of	What Country?			
23a or	6099 Foxtail Ct				21801		USA				
ded within 72 hours effer death with the Maryland Vglene. Nor than "natural", or items 23s or 28s-f show it, the Medical Examiner must be notified at Completed by Funeral Director	11. Marital Status 1 Navied 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forces? 1 ☐ Yas 2 ☒ N If Yes, Giva Yaar or Datas:	34.5		edant of Hispanic C ecify Cuban, Mexico 200 No Specify	Orlgin? (Specify Yes an, Puerto Rican, et y:	or No- c.) 14. Ra Ble Specia	ce - American Indian, ick, Whita, etc. White			
natur natur Jeted	15. Decedant's E (Specify only highest gr		16	a. Decedent's Us	ual Occupation work dona during me	ost of working	16b. Kind of E	Businass/Industry			
ithin npi	Elementary/Secondary (0-12)	College (1-4or 5-	+)	lifa. DO NOT	usa ratired)		27 /2				
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2 sho end is m sum	19a. Informant's Neme/Ralationship		19				Number, City or Town				
s 1 and if Health Item 27 other tr	Eric & Anna Pran	dy/Parents					ry, MD 218				
00-2	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Speci			of Disposition (A ery, crematory o Lico Mem	ama or rothar placa) orial Par	Data k 3/16/		- City or Town, State Oury, MD			
permit. Pag Department Important: i any injury c	21. Signatura of Funeral Sarvice	lung	a OFSI	Holl	and Addrass of Fac Oway Fune	ral Home	Profession	ofessional Associatio			
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E 0 8	that initiated evants resulting in death) Lest Due to (or as a consequença of):										
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been si should						. Was an autopsy performed?	24b. Were autopsy findings availabla prior to completion of causa of death?				
The lew ata has to page 2 s							.W	1/			
icata r, pa							1X Yes 2□ No	1 Yas 2 No			
stcian: The lev certificata has lirector, page 2 o Be Comp	25. Was case rafarred to medical examinar?	Hospital:			Other:	ca of Daath (Check					
ng Phys fter this uneral di	1 ☐ Yes 2 ☑ No 27. Mannar of Death 1 ☑ Natural 5 ☐ Panding	28a. Deta of Injur (Month, Day	y 28b	Time of Injury	28c. Injury at Work?	28d. Das	Rasidance 6 On scribe how injury occu				
To the Hospital or Attanding Physician: The lev within 24 hours aftar death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	2 Accidant invastigatio 3 Suicida 6 Could not b 4 Homicida datarminac	e one Diese of Iniv	ry - At homa, (Spacify)	M farm, straat, fact	1 ☐ Yes 2 [ory, offica	ation (Straat end Nurr or Town, Stata)	ber or Rural Routa Number,				
he Hospita in 24 hours he Funeral plataly filled	29a. Certifiar 1 Cartifying Pl (Check only 2 Medical Example)	nyelclan: To the best of miner: On the basis of and mannar sta	axamination a	ge, death occurre nd/or invastigati	ed et tha tima, deta a	and piece, and due eath occurred et the	to the causa(s) and n time, date and place	nanner es steted. , and dua to tha causa(s)			
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	31. Data filed (Month, Day, Year)	32. Ragistra	r's Signatura	1	back						

State of Maryland / Department of Health and Mental Hygiene

1. Dec	dent's Name (First, Middle,	Last)	-	C	ertifica	ate of	Death	2. Date of De	Reg. No.	1	3. Time of Dea
cian lical	Florence	Ε.		Pea	per			March		J 999	11:29A
iner 4a Fac	ility Name (If not institution,						4b. City, Town, or Clinton				orge's
E Cook	thern Marylan Security Number 6	. Sex 7. Ac	e (In yrs. l	ast birthda	(v) If Unc	der 1 Yea					lace (State or Fo
	-12-7022 Residence of Decedent	1□ M 2 F	76	Yrs.	Month	S Days	Hours Min.	8. Date of Bir (Month, Be Aug. 8	, Y1922	Mary.	
10a. St	ate 10b. County			, Town or						1	0d. Inside City Li
X	land Charle	3	Wa	ldor							1 Yes 2
	2550 Lisa Dr.	ive				Zip Code 2060				.S.A.	
10 30	ital Status Never Married 2 AMarried Widowed 4 Divorced	12. Was Decedent Armed Forces? 1		S. 1		cedent of pecify Cu	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specil	ce - Americ ck, White, Wh:	
letec	15. Decedent's (Specify only highest)	Education grade completed)		16a. De (Gi	ve kind of	sual Occi	upation e during most of wor ed)	king	16b. Kind of B	usiness/Inc	dustry
Completed	entery/Secondary (0-12) 12th	College (1-4or s	5+)		ervis		90)		Federa	l Gov	ernment
17. Fat	ner's Name (First, Middle, La						18. Mother's Nar		, Maiden Sumai	ne)	
17. Fat	Unknown			PIG			Ur	known			
19a. In	formant's Name/Reletionship Harry R. Peap			255	0 Lis	sa Dr	ive Waldo	orf, Mar	er, City or Town yland 2	, Stete, Zip 0601	Code)
10	athod of Disposition Burial 2 Cremation 3 Donation 5 Other (Spe		20b. Pi	ace of Dis metery, c	position (A rematory of Stat	iame of r other pi ce Ve	March Leterans Ce	29, Date 1999 m.	20c. Location		wn, State Marylar
	nature of Funeral Service Lic						ress of Facility Alexandri		eral Ho	me, I	nc.
diseas resultii	iate Cause (Final e or condition g in death) Intially list conditions, eading to immediate Enter Underlying (Disease or Injury lated events	a. Van			sequence of		1 D18015				Onset and Deet
Cause that init resulting	Disease or Injury lated events g in death) Last	d	Due to (or	as a cons	equence o	f):					
Physician/	Other eignificant conditions	contributing to death b	ut not resu	lting in the	underlyin	cause o	iven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of d
								10	Yee 2 No	3 Prof	bably 4 ☐-t/fil
Completed by								24a. Wes	an eutopsy ormed?	av	ere autopsy findio ailable prior to mpletion of caus death?
ф								10	Yes 2 10		N/A Yes 2□No
9 25. We	s case referred to medical miner?						26. Place of De	oth (Check only	one)		
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27. Mar 1 2 2	Natural 5 Pending Accident Investigat		y Year)	28b. Time Injur		28c. Inj W 1[ury at ork? □ Yes 2 □ No	28d. Describe	how injury occu	rred	
4C	Suicide 6 Could not determine	building, et	c. (Specify)				City or To	wn, State)		al Route Number,
	ertifier 1 Certifying in the ck only 2 Medical Ex	Physician: To the best aminer: On the basis of magner st	examinati	rledge, de on and/or	ath occurre investigati	ed at the on, in my	time, date and place opinion, death occu	, and due to the irred at the time,	date and placa,	anner as s	tated. the cause(s)
	gnature and title of certifier	11		_	1	29c. Lice	nse number		29d. Date sign	ed (Month,	Day, Year)
20.11	/kentf.	Profer	Contract in	200	P. P.	D:	30135		March	22,	1999
	ne and address of person wh Kenneth T. La					Road	EM Dept	Clintor	. Maryl	and 2	20735
	e filed (Month, Day, Year)		ar's Signat			2000	bopo		,		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GEORGE PARRISH MARCH 20, 1999 2320 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) Prince FRederick Calvert ar If Under 24 Hrs. 8. Dete of Birth (S Hours Min. (Month, Dey, Year) 9. Birthplace (Stete or Foreign Country) If Under 1 Year If Under A 5. Social Security Number ₩ 2□ F Months Yrs. 84 July 18 1914West Virginia 235 05 3685 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Calvert Lusby 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10979 Elm Drive 20657 United States 12. Wes Decedent Ever in U,S. Armed Forces? X□ Yes 2□ No If Yes, Give Year or Dates: WWI Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried WWII 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail sales salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Addison Parrish, Sr. Lavinia Pyatt 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10979 Elm Drive Lusby, Maryland 20657 Ina H. Parrish - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery Date 20c. Location - City or Town, State 26 1999 Cheltenham Maryland 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 206 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ulmonary Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? dialysis dependent renal failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or flems 23a or 28a-f show traumetic event, the Marical Exposurer must be notified at

e filed within 72 hours efter deeth of Hygiene. other than "natural", or Items 23

12 should be fi h end Mentel H is marked of

permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m any injury or other traum pncs.

the Meryland

Physician/Medical Examiner ettending physicien end for use es the buriel-transit 98 signed by the e by Completed peen : hes certificate ! Be 10

The law requires that the death certificate be executed

Box 68760

Division of Vital

Physicien:

Hospital or Attending

To

this : After this Certification: in 24 hours effer death.
The Funerel Director: Aft

colon (auce).

coronary artery disease, renalcancer, 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☐ No 27. Manner of Death T Netural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Dey Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ Ne

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) and manner es steted.

2 Madical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

2000

29c. License number

29d. Dete signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Jonathan K. Fears, M.D. Prince Frederick, Maryland 20678

State Registrar

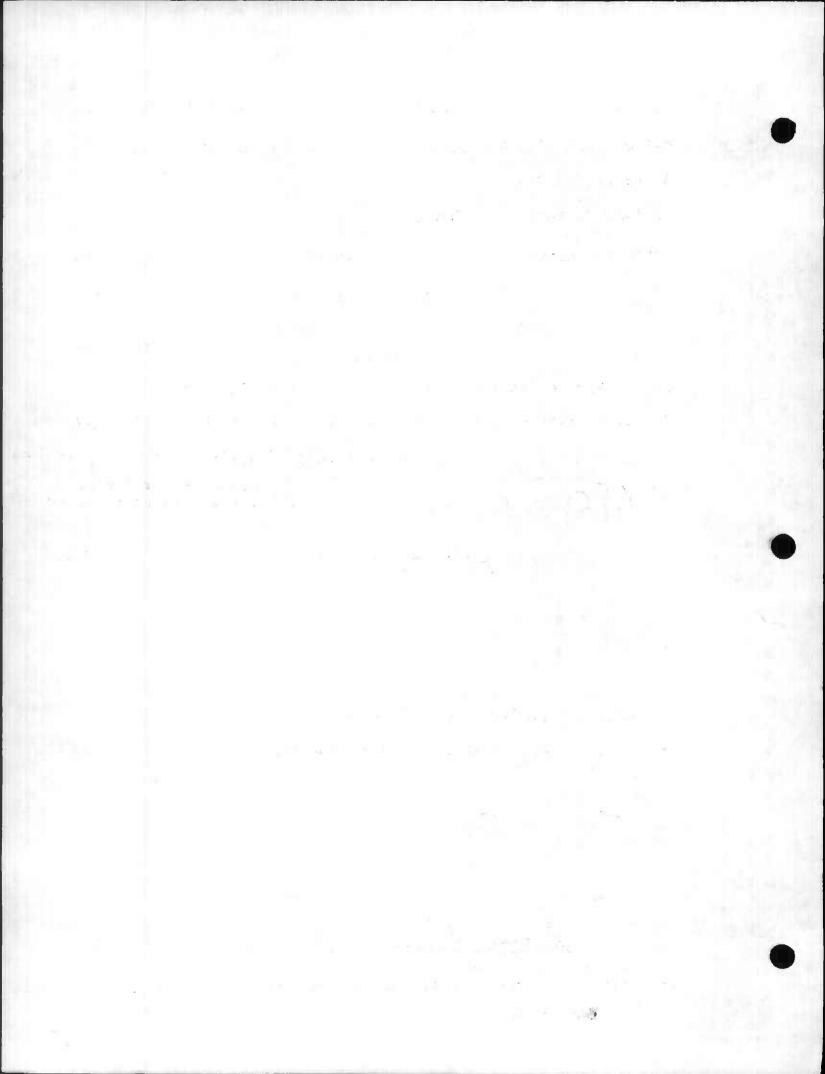
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29e. Certifie

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within 2 the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH **JACQUELINE** QUINN 1433 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer, 9. Birthplace (State or Foreign Deys Hours 1□M 2XF 212-24-9922 69 DEC. 4, 1929 MARYLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No SUSSEX SELBYVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 90 SALTY WAY EAST, KEENWICK WEST 19975 USA Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decadent Ever in U,S. 14. Rece - American Indien. Armed Forces Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 2 No 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorcad Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Η. WEBSTER MILDRED HILLYER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROBERT J. QUINN/HUSBAND 90 SALTY WAY EAST, SELBYVILLE, DELAWARE 19975 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete cametery, cremetory or other piece) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 3/22/99 HURLOCK, MARYLAND MARYLAND VETERANS CEM. ora Servica Licensee 22. Name end Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 nier the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) utricular to brillation 30 mm erolaterel myor Hial

Physician /Medical Examiner

attending physician end for use as the buriel-tren

signed by the detech

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Certification:

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the Mospital or Attanding Physician: hin 24 hours effer death. the Funeral Director: After this certifice

filled in by the f

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To the within

The law requires that the death certificete be executed

P.O. Box 68760,

Records,

Division of Vital

Physician

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Examiner

10a. Stete

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11. Maritel Status

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21. Signatury

Director

Funeral

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Completed

Be 2

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny Injury or other traumetin.

SHC GUELIN (VUINN) スノユータチー タタスス altimore, Maryland 21215-0020

Physician/Medical Examiner by Completed

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest

Due to (or as e consequenca of): Due to (or as e consequenca of): arter esse

Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy periormed? diseoso 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

29a. Certifier

31. Dete filed (Month

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) end menner stated.

29b. Signeture and title of cartifier

29d. Date signed (Month, Dey, Year)

in Phone Drive

MD 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 614

State Registrar alal MD 32. Registrar's Signeture

2180

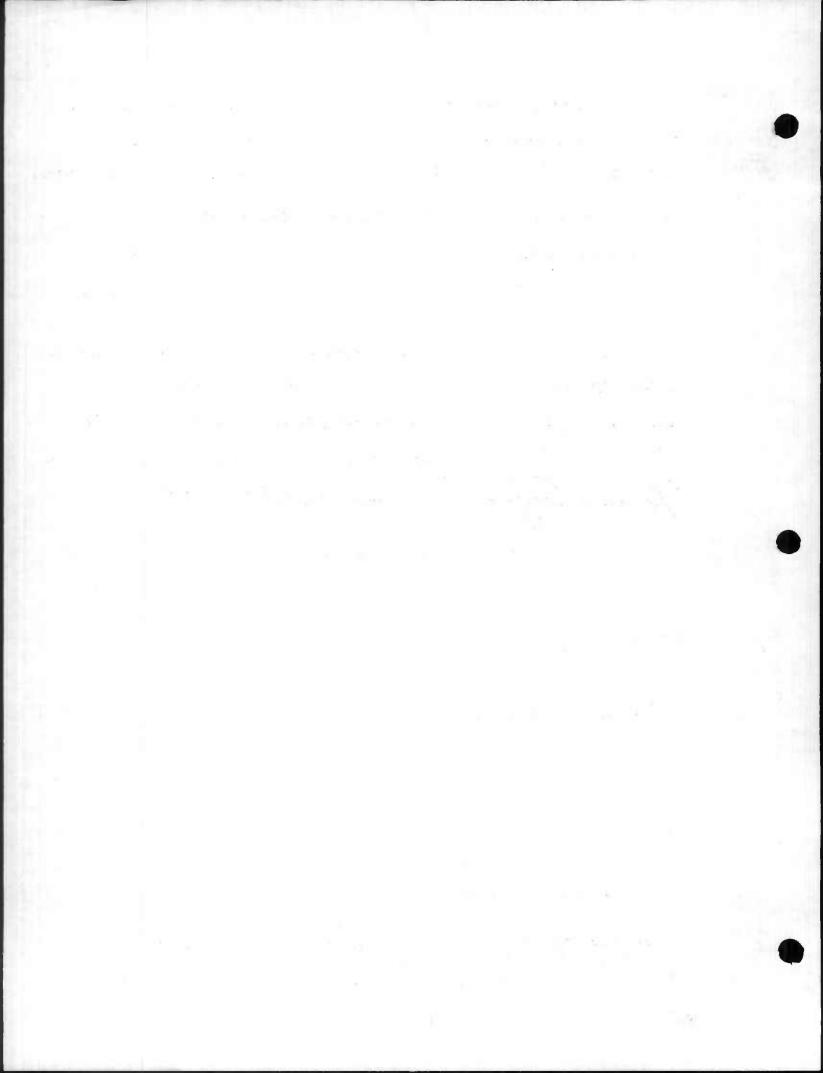


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles Reynolds March 1999 1:50 PM /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Center Cecil Rising Sun 5. Social Security Number if Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 10XM 2□ F Months Hours 78 Yrs. Director 168-12-0909 Sept. 13, 1920 Pennsylvania Usuel Residence of Decedent with the Maryland 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Insida City Limits Director 1 ☐ Yes 2 X No Chester Londonderry Twp. Cochranville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19330 2099 Newport Gap Pike USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after I XYas 2 □ No If Yes, Give 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white by 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: W W Completed 15. Dacedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) sith and Mantal Hygiena. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 10 line person/parts auto manufacturing 17. Father's Name (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Maidan Sumama) . Pages 1 end 2 should be fil iment of Health and Mantal H lant: If Item 27 is marked oft jury or other traumatic even Be Jerome Reynolds Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Philadelphia Pike, Wilmington, DE 19809 Edwin L. Blevins 20b. Placa of Disposition (Nama of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 3/25 Kennett Square, PA Longwood Cemetery 21. Signature of Funeral Service Lices 22. Name and Address of Facility #123 Kuzo & Gofus Funeral Home, Ltd. Kennett Square, PA 234. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one of use on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final WICE disaase or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner B-S.CVD YRANS bunial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician s tha burial Box 68760. Physician/Medical Due to (or es a consequence of): USB BS Pot P.O. I ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? paga 2 should Completed 24a. Was an autopsy has Aftar this certificate 1 Yes 20 No of Vital or Attending Physician: director. Be 25. Was casa raferred to medical 26. Piece of Death (Check only one) Other: 412 Nursing Home 5 Residenca 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To s aftar death.

Il Director: Aftar this ed in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide within 24 hours a Hospital 152 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical сотрывату (Check only the 29b. Signature and title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 1)-11115 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Rising Sun, Md 21911 15+1VA Ir MO Ve1) MH Laylor 32. Registrar's Signatura 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene 99

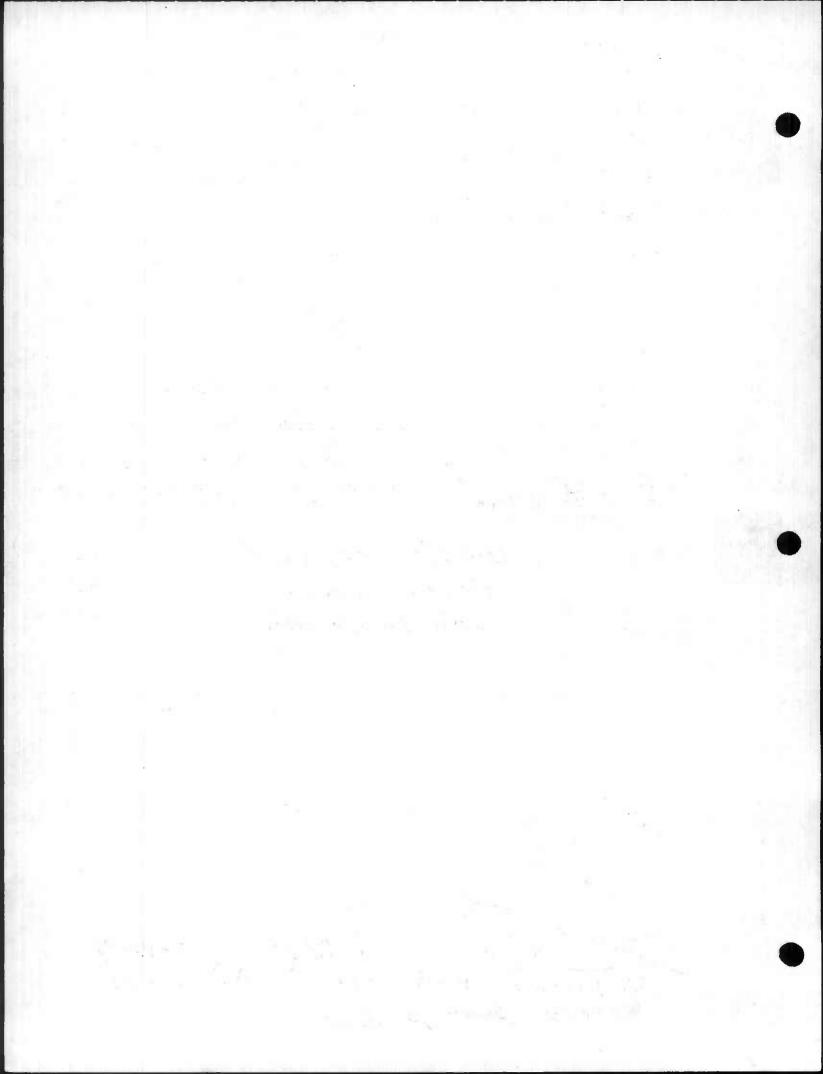
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	ylend		10a. State	10b. County		10c. C	ity, Town or L	ocation						1	0d. Inside City Limits
	a Mar	cto	MD	Allega	ny		LaVa]	_e							1 XYes 2 □ No
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ylai		To	Willi	iam B. Ro	bb, Sr.					Wi	llie	C. (Wi	lson)		
Maryland	and and a m		19a. Informant's I	Name/Relationship	(Type, Print)		19b. Maili	ng Addrass	(Street	and Numb	er or Rura	i Route Numb	er, City or Town,	State, Zip	Code)
	EZNE			Robbw	ife	1-2-			-	Aver	ue;	LaVale		502	
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Baltimore,	t. Pa tmen tant:		4 Donation	5 ☐ Other (Spec	rify)	R	locky G	ap Vet	era	ins Ce	m	03/22	Flint	stone	, MD
Bal	permit. Page Depertment of Important: If any Injury or once.		21, Signature of F	Funeral Service Lio	ennee A	N	22. Name and Address of Facility Scarpelli Funeral Home, P.A.								
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	Physician /Medical		Immediate Cause	e (Final	K	mole	500	1	NI	1 000	mad	1.9	1		Onset and Death
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o.	0 9 6	Physician	Part II. Other sign	ificant conditiona	contributing to d	leath but not ra	sulting in the u	nderlying ca	use giv	ven in Part I		23b. Dld	tobacco use co	ntribute to	the cause of death?
Δ.	that the ed by th detechy											1 02	Yes 2□ No	3 Prot	bably 4 Unknown
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00	TI (0)	lete										perfe	ormed?	ava	ailable prior to impletion of cause
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jo	Attending or daath. octor: Attai	atio	1 Natural 2 Accident	5 Pending investigation	on	iiii, Day 19ai)	Injury	М	Wor 1 □	Yes 2	No				
Division	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	1 28e. Placi	a of Injury - At h	home, farm, str	eet, factory,	office		1	28f. Location (Street and Numb	er or Rura	l Routa Number,
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	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this cartific complately filled in by the funeral director.	edical	29a. Certifier (Check only post)	1 Certifying P 2 Medigili Exa	miner: On tha b	asis of axamin	owledga, daatl ation and/or in	occurred a vestigation,	t tha tir in my o	ma, date an opinion, dea	d place, a	and dua to tha	causa(s) and ma	nnar as st	ated. the cause(s)
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ROSWELL, 1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month MARGARET March 15, MTLLS ROSWELL 1999 /Medical 2:20 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner MANOR CARE NURSING HOME LARGO
If Under 24 Hrs.
Hours Min. PRINCE GEORGES If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Birthpiece (State or Foreign Country) Deys 1□M 200 F Yrs Director 214-10-8599 84 June 25, 1914 Maryland Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maucal Examinar must be notified at 28a-f show Maryland Prince Georges Director Largo 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 600 Largo Rd 20774 Funeral death USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgln? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours efter Yes 2 No f Yes, Give feer or Detes: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Housewife Domestic 12 Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 end 2 should be filt ment of Heelth end Mentel Hy ant: If Item 27 is merked oth ury or other traumatic even Be Henry Mills Shanarah Nichols 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donald R. Roswell/Son 1805 Crystal Dr., Unit 1016, Arlington, VA 22202 Baltimore, 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 XBurlel 2 Cremetion 3 Removel from Stete Depertment of important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 3/18/99 Wicomico Memorial Park Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21: Signature of Funeral Service Licensee M01051 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Physician Immediate Ceuse (Final disease or condition resulting In deeth) /Medical Examiner Examiner The lew requires that the death certificate be executed pue the buriel-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest on cepholas Box 68760. ettending physiclen for use es the burie Physician/Medicai signed by the et Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? certificate 1 Yes 2 JUNO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: Vursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? edical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturei deeth. 1 ☐ Yes 2 ☐ No 2 Accident ofter deeth Director: in by the 3 Sulcide 6 Could not be 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral D completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Madical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) 29e. Certifier the 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Yeer) 30 Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ava Ko 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 1 8 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** 1630 RITCHINGS PEYTON March 1999 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WICOMICO PENNINSULA REGIONAL MEDICAL CENTER SALISBURY if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. 222-20-1302 Director 82 November 25,1916 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Maryland Wicomico Salisbury 1 ☐ Yes 2X No Director the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 419 Elberta Ave. itеля 23a 21801 USA Funeral death 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW TT Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritai Status 72 hours after 1 ☐ Never Married 2K Married 'natural', or 21215-0020 1 ☐ Yes 2 ☒ No Specify: Army WW II Specify: 20 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry should be filed within 7: ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Doctor Medicine altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) . Pages 1 and 2 should be fill timent of Health and Mental Hitant: If item 27 is marked oth jury or other traumetic even Edward Ritchings Mary Peyton Welch 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Frances B. Ritchings/Wife 419 Elberta Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 3/15/99 Salisbury, MD 5 Other (Specify) Salisbury Crematory 4 Donation re a Funeral Service Licenses 22. Name end Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical PNEUMON.A MON. Examiner Due to (or as e consequence of): Examiner certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequença of): physician a 68760 Physician/Medical Due to (or es e consequence of): 98 Box (Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? signed by it 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown COPD Records, by 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? ABDOMINAL ILEUS page 2 1 ☐ Yes 2 ZNo 1 ☐ Yes 2 ☐ No certificate Vital or Attending Physician: director. 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA of funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After 5 Pending investigation 1 Haturel s after dea... 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funerel Discompletely filled 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examíner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. edical 29a, Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 029/68 ale M. D. 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 560 Riverside Dr. A204 Salisbury, MD 21801 M.D. 32. Degistrar's Signature State Registrar

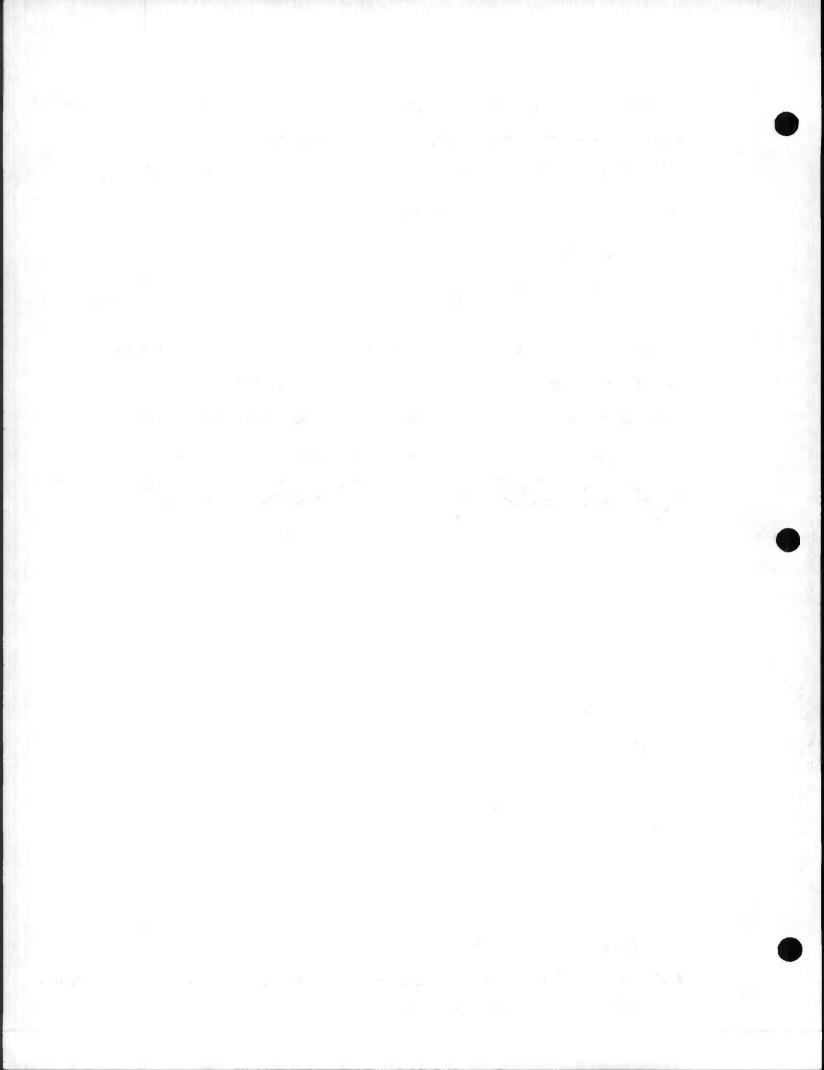
DHMH 16 Rev 6/95

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Ritching

Edward P.



				Cer	tificate of	Death		Reg.	No.		
	1. Decedent's Neme (First, Middle, Li	est)	-					te of Deeth	Devi	Vaar	3. Time of Death
Physician	Ardrilla Mar	ie Red	ding					ARCO		Yeer 4 5 9	18:15
/Medical Examiner	4a Facility Name (If not institution, gir					4b. City, Town			4c. County o	1-1-1-	
Examiner	PENINSULA REGION	AL MEDICA	AL CENT	ER		SAI	LISBURY		WIC	COMIC	00
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Director	216-56-0618	1□M 2MF	47	Yrs.	Months Deys	Hours	Min. Ma	te of Birth onth, Dey, Ye r. 29	1951	Mar	ylan d
Q	Usuel Residence of Decedent										
how	10a. Stete 10b. County		10c. City,	Town or Lo	cation					10	0d. Inside City Limits 1 Yes 2 □ No
the Marylar 28a-f show notified at	Maryland Wico	mico	Fr	uitl	and						TA TOS 2LINO
vith the Ma t or 28a-f s	10e. Street end Number				10f. Zip Code			10g.	Citizen of WI	het Coun	try?
death with the Maryland ms 23a or 28a-f show Insust be notified at		ue			2182	6			U.S.A		
	11. Maritel Status	12. Was Decede Armed Force	ent Ever In U,S	. 13. \	Vas Decedent of I Yes, specify Cub	Hispanic Originan, Mexicen,	n? (Specify Yo Puerto Rican,	etc.)		- America , White,	en Indian, etc.
5-0020 72 hours after matural; or the		Armed Force 1 Yes 2 If Yes, Give	No	E 80	Yes 2 No	Specify:			Specify:		
15-0020 72 hours af 'natural', or		Yeer or Date								Blac	
121215-0 ed within 72 ho yojena. The water nature of the water of the	15. Decedent's E (Specify only highest gi	ducation ade completed)		16e. Deced	lent's Usuel Occup kind of work done OO NOT use retire	petion during most o	of working	160	o. Kind of Bus	iness/inc	Justry
	Elementary/Secondary (0-12)	College (1-4	or 5+)		nestic	<i>,</i> u)			None		
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		1)		DO	HESCIC	18 Mother	s Neme (First			a)	
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Social Services and Menical Me		(Time Driet)		40h Mailie	a Address (Street		n Joh		ihi or Tourn	State Zin	Codel
Mar Mar Mar Mar Mar Mar Mar Mar Mar Mar	19a. Informent's Name/Relationship		h tram \	111-111-111							0000)
re, No. 1 and a them 27 other tr	Carmeletta Cai	ii (Daugi			Morris sition (Neme of	St.FI	Det		Location - C		wn Stete
Pages Tani of Inc. If He	1 Burial 2 □ Cremation 3 [ete	netery, crer	netory or other pla		3/	131			
tim tanti	4 Donetion 5 Other (Special	**	Cot		Grove				estov	er,	Md.
Baltimore, Maryland pamit. Pages 1 and 2 should be filed Department of Health and Mental type important: if item 27 is marked other any injury or other traumatic avent, once.	21. Signature of Funeral Service Lice	nsee A	Α.	S	Name end Addre	Funer	al Ho	me			
_ 402#4	Iladys 8	· Stee	vart			Rd.S				01	
1	23a. Pert1. Enter the di Asse, or con shock, or heert fair re. List only	nplications that cau y one ceuse on eed	ised the death. th line.	Do not ent	er the mode of dy	ing, such es c	ardiac or resp	iratory errest			Approximete Intervel Between
Physician											Onset end Death
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	. 1	BRAIN	1 D	EATH	-					
			Due to (or	es e consec							
D, executed in and inal-transit Examiner		b. M	A-SSI	UF	SUBAR	ACHN	010	HE MO	PRHAC	XE.	
and -tran	Sequentially list conditions,		Due to (or	es a consec	uence of):						
50,		C									
68760, ficate be executed physician and is the buriat-transit edical Examir	that initiated events resulting in deeth) Last		Due to (or a	as e conseq	uence of):					į	
		d									
P.O. Box 687 at the death certificate by the attending physicate for use as the Physician/Medic											
O e de d	Pert II. Other significant conditions	contributing to deal	th but not result	ting in the u	nderlying ceuse gi	iven in Part I.	2	3b. Did toba	1		the cause of death
P.O. that the detache detache								1 Yas	2 18 No	3 Prol	bably 4 Unknow
<u>o</u> 8 5 8 0							_	4a. Was en e	utoney	24h W	ere autopsy findings
Ords requires een sign hould be								performe	d?	ava	aileble prior to impletion of cause
law law										of	death?
I Record The law requir sate has been s page 2 should								1 🗆 Yes	2 No	1[Yes 21 No
of Vital Ro Physicien: The lattic certificate he rel director, page	25. Was cese referred to medical						of Deeth (Che	ck only one)			
hysic aldire	1 NYes 2 No	Hospital: 1 In		R/Outpatier	I 3LI DUA		sing Home 5				וע
on of Vital Re- sing Physicien: The lav h, After this certificate has funeral director, page 2 tion: To Be Comp	27. Manner of Death 1 DNaturel 5 Pending	28a. Dete of (Month,	Injury 2 Day Year)	28b. Time of Injury	We			escribe how	injury occurre	ed	
Vision Attending or death. ector: Attention tification	2 Accident investigation				M 1	Yes 2 N					
Division of the or attending P is after death. In Director: After the diner. In Director: After the diner. Certification:	3 ☐ Suicide 6 ☐ Could not determined	200. Flace 0	f Injury - At hon , etc. (Specify)	ne, farm, str	eet, factory, office			cation (Streetly or Town, S		er or Rura	al Route Number,
2 5 2 9 O											
he Hospi in 24 hou he Funer pletely fill	29a. Certifier 1 ☐ Certifying P (Check only 2 Medical Exa	hysician: To the be miner: On the bas	est of my know	ledge, deetl	occurred at the treatment occurred at the treatment of th	time, date end opinion, deeth	plece, and du occurred at t	he time, dete	se(s) end mar e end place, e	nner as s	teted. the cause(s)
thin 2, the homelet will be made a manual med		end manne	r stared.	[]							
To T		MD, PhD	10	1	DO	05404	48	290	Dete signed	3/99	
	L'Accort		(Jung)	\sim $^{-1}$	> HT	0497		-	/	, .	
	30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Christopher SN49er DME 108 PINE BLUFF RO SALISBULY, MD										
0	TACCK MALL		ED RIVEY:		r. SUTTE.	102 SA	usbyry,	MD			37.
State	31. Date filed (Month, Dey, Year)		istrer's Signatu	ire /	1		7				
Registrar	WAR 11	399	and the same	D	Soan	Kal					

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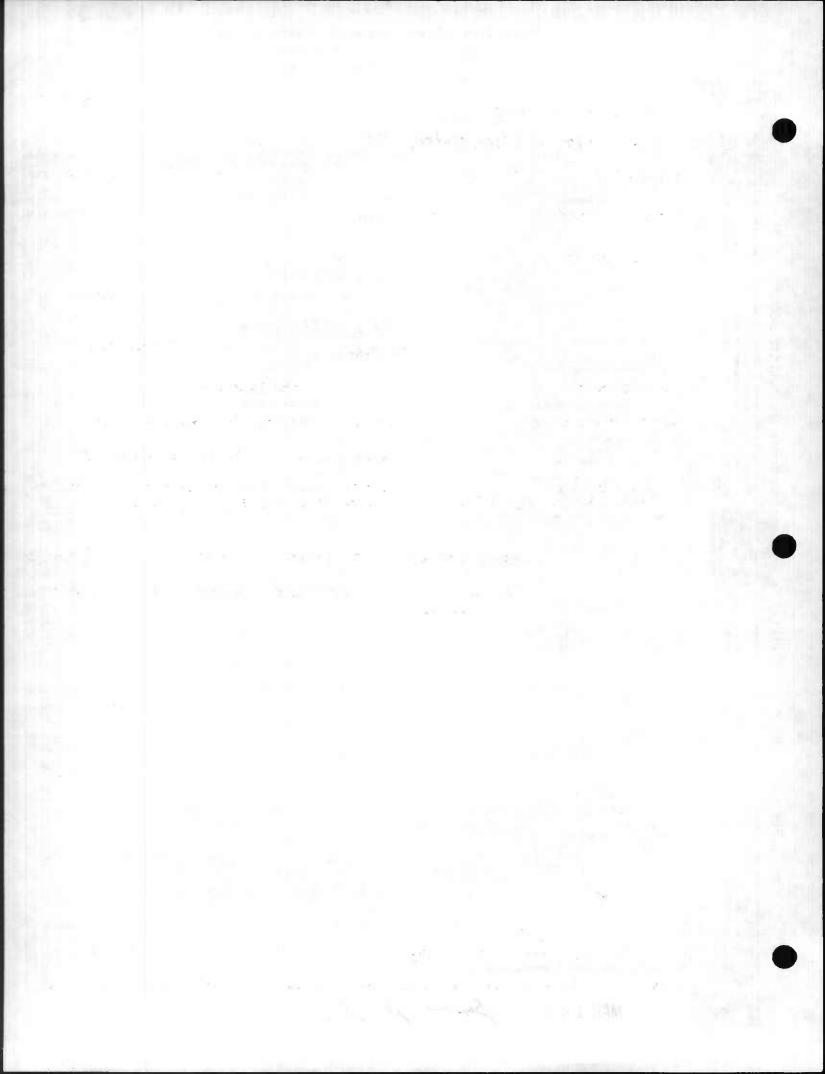
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Yeer 4:20 PM **Physician** 3 99 MURIEL M. REINKEN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Ct 27860 CLEARWATER MD WICOMICO SALISBURY HOME Birthplace (State or Foreign Country) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Min. Months 1 □ M 2 🔀 F Hours May 1,1921 Director New York 131-05-7708 the Marylend 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or itema 23a or 28a-f show trsumatic event, the Wed cal Examiner must be notified at Florida Volusia 1 ☐ Yes 2 ☐ No Port Orange Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? WITH 48 Windward Ct 32127 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Merite! Status Bleck, White, etc. 72 hours efter 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Bookkeeping Bookkeeper 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event Be Elbert Rouse Estelle Maver 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Interment's Name/Relationship (Type, Print) Stephen Reinken/son 27860 Clearwater Ct., Salisbury, MD 21801 altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method ot Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal trom State 3/15/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association CFSA 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Interval Between Onset end Deeth 23a. Part1. Enter the disease, or compilications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) CARCINOMA WITH EFFUSION RIGHT MONTHS Examiner Due to (or es e consequence of): Examiner CHRONIC ISCHEMIC FOOT VICER LEFT WITH -2 YEARS the death certificate be executed physician end s the burial-trans Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest CHRONIC PAIN Box 68760 Physician/Medical Due to (or es e consequence ot): 9 USB for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed peen completion of ceuse of deeth? has page 2 1 Yes 25 No 1 Yes 21 No certificate director Be 25. Wes cese reterred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) funerel 27. Manger of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: of the death.

Olrector: After 1 After 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 24 hours e 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier grylins, M.D 050929 3-15-99 MADARANG-LEWS, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MO 21804 MADARANG-LEWIS 5745BURY 1405 S. DIVISION ST

State Registrar Day, Yeer)

MAR 1 6

32. Registrer's Signeture



	State of	of Marylan	d / Depa	artment	of h	lealth a	nd M	lental Hy	giene	922		0000
				rtificate					Reg. No			
1. Decedent's Name (First, Middle	a, Last)							2. Data of De			Van	3. Time of Deeth
	Frances L	ydia Sh	ires					Month March	20	1	Year 999	8:15 p.m.
la Facility Name (If not institution	, give street end nu	m <i>ber</i>)			1	b. City, Tov	vn, or Lo	cation of Deet	h 40	. County	of Death	
Residence: 10	7 Love Ru	n Road				Co	lora	a		C	ecil	
5. Social Security Number	6. Sex	7. Aga (In yrs.	lest birthdey)	If Undar 1 Months		If Under 2	24 Hrs. Min.	8. Dete of Bir (Month, De	th ev. Year		9. Birthp	oleca (Stete or Foraign
215-32-7620	1□M 2] ()F	91	Yrs.	WORKING	Days	7,0015	191011.	August	1,1	907		aryland
Jsuel Residence of Decedant		40- 04										Od to stds City t imite
10a. Stata 10b. County		10c. Cit	y, Town or Lo	ocation		0.1.						0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Maryland Ce	cil					Color	а					**
0e. Street and Numbar				10f. Zip C	ode				10g. Ci		Whet Cour	
107 Love Run Ro	oad					21917				U	J.S.A	•
1. Marital Status	12. Was Dec	edant Ever in U	,S. 13.	Was Decede If Yes, specif	nt of h	lispanic Orig	in? (Sp., Puerto	ecify Yes or No Rican, atc.))-		e - Amaric ck, White,	ean Indian, etc.
1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, Gi	2XXNo ive		1□ Yes 2		Specify:				Specify	/:	
③OXWidowed 4 □ Divorced	Yaar or E)ates:									W	hite
15. Decedent (Specify only highest			16a. Dece (Give	dent's Usual kind of work DO NOT use	done	ation during most	of work	ing	16b. F	(ind of B	usiness/In	dustry
Elementary/Secondery (0-12) Six Years	College (1-4or 5+)	ите.	Homem					Per	sona	al Re	sidence
7. Father's Name (First, Middle,	Last)					18. Mothe	r's Nem	e (First, Middle	, Maider	Sumen	10)	
LeRoy	Reynolds						Mai	garet	Barr	OW		
19e. Informent's Name/Relations Ruby McGlothli		er)						ora, Ma			State, Zip 2191	_
0a. Method ot Disposition 1 △ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Co	Plece of Disponentery, cre Dnowin Churc	osition (Nemo metory or oth go Bap n Ceme	e of her ple tis ter	ce) t y	3	Date /24/99				own, State Maryland
21. Signature of Funeral Service	M Patt		L	2. Name and	Pat	ss of Facilit	n &	Son Fu	nera 03-0		me	
23a. Part1. Enter the disease, or shock, or heart tailure. List	complications that only one causa on	caused the deat each line.	th. Do not an	tar tha mode	of dyi	ng, such as	cardiac	or respiratory a	arrast,	100		Approximate Interval Between Onset and Death
resulting in death)	Rem	Due to (d	or este conse	quenca ot):	nic	Rag						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	c	Due to (c	or as e conse	quence ot):								
that initieted events resulting in deeth) Last	d	Due to (o	or as a conse	quenca of):								
Pert ff. Other significant condition	ne contributing to a	leath but not rec	ulting in the	inderlying ca	use oi	on in Part I		23h Did	Itohacc	o uaa co	etribute t	to the cause of death?
Portic Wu	en Me	me	outing in the t	andenying da	use gi	7011 111 1 01(1			Yes		3 Pro	1/
1 1/.	•							24e. Was	s en eute ormed?	opsy	av	ere autopsy tindings veilable prior to completion ot cause t death?

Physician /Medical Examiner

Physician /Medical

Examiner

Funeral

Director

permit. Pegas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, five Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

25. Was case reterred to medical examinar?

1 Yes X No

27. Manner of Deeth

1 Netural

2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check only one)

Director

Funeral

by

Be Completed

To

Examiner The law requires that the deeth certificate be axecuted Physician/Medical Completed by Be Medical Certification: To

within 24 hours after death.

To the Funeral Director: After this cartificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be dateched for use as the bunel-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

State

Registrar

(Month, Dey, Year)

2 3 1999

5 Pending investigation

6 Could not be determined

3□ DOA

28c. Injury et Work?

1 Yes

2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner es stated.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end mannar stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient

28b. Time of

28e. Placa of Injury - At home, term, street, tactory, office building, etc. (Specify)

Hospital:

28e. Date of Injury (Month, Day Year)

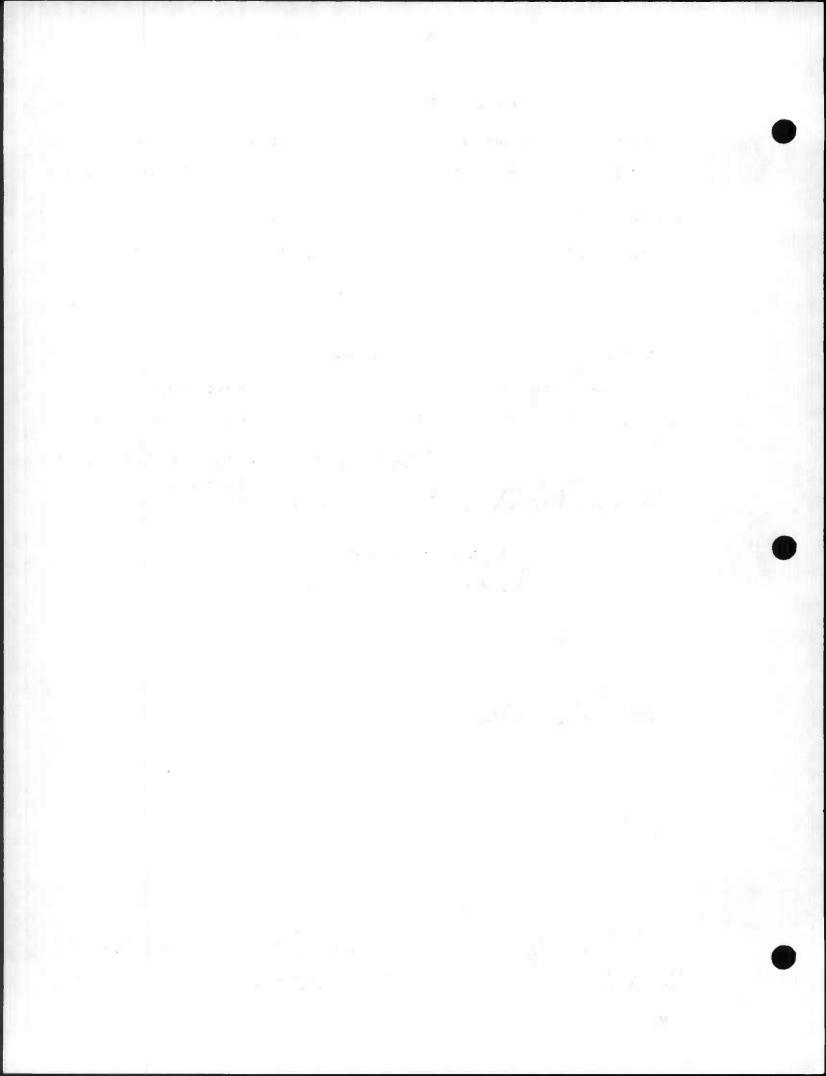
26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 N Residence 6 Other (Specify)

28d. Describe how injury occurred

32. Registrar's Signatura

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1 Decedent's Name (First Middle Last) 3. Time of Deeth **Physician** 19,1999 Ruby Gertrude Simmons March 2:37am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street and number) Examiner 5055 Marbury Run Road Marbury
If Under 24 Hrs. Charles If Under 1 Year 8. Date of Birth 9. Birthpiece (State or Foreign (Month, Day, Year) 4 Maryland Maryland 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 XF Deys Hours Min. 84 Yrs. 215-44-3573 **Director** Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits / Is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Wedical Examine mainton nothed at 1 ☐ Yes 2 ☐ No Directo Maryland Charles Marbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5055 Marbury Run Road 20658 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bieck, White, etc. filed within 72 hours after Hygiana. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White P 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) U.S. Government Telephone Office Manager permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important. If them 27 is marked other any injury or other traumatic event phose. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie C. Wheeler, Sarah Martina Henderson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Patricia A. Long Same as #10 20b. Piace of Disposition (Name of cemetery, crematory or other place) March 23, 1999 Waldorf, MAryland Baltimore 20e. Mathod of Disposition 1 Buriei 2 Cremation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Williams Funeral Home, P.A. 20640 M00668 4270 Hawthorne Rd., Indian Head, Maryland 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) EMENTIA 14 Examiner Due to (or es a consequenca of) Physician/Medicai Examiner attending physician and for use as the bunal-transit certificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceusa (Diseese or injury that initieted events resulting In deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or es e consequence of): law raquiras that the death ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, Š 24b. Were eutopsy findings eveileble prior to should t 24a. Was an eutopsy performed? Completed completion of cause of death? cartificata has Tha 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital Physicien: 25. Was case referred to medice examiner? Be 26. Piece of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this in 24 hours after death.
the Funeral Director: After the funeral 28a. Deta of Injury (Month, Day Year) 27. Manner of Deeth 1 Naturel 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation or Attending 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Confifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end dua to the ceuse(s) end menner as stetad.

2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, daeth occurred et tha tima, deta and place, and dua to the causa(s) end menner stated. 29a. Certifiar edicai completely (Check only one) within 2 29b. Signetyre end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D28352 MARCH 22, 1999 30. Nama end eddrass of person who completed cause of death (Item 23e) (Typa, Print)

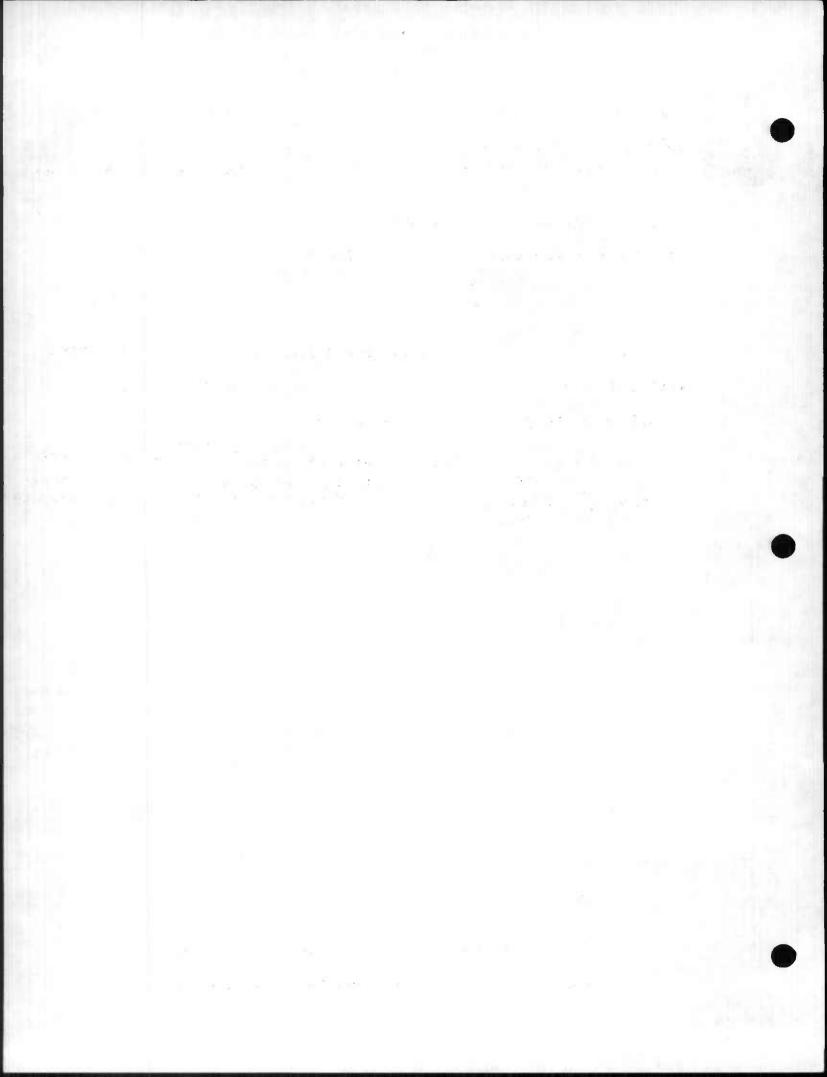
Registrar

31. Dete filed (Month, Day, Year) 32. Registrar's Signature MAR 23 Ornera

Krishan Mathur,

MD., P.O. Box 2729, La Plata, MD

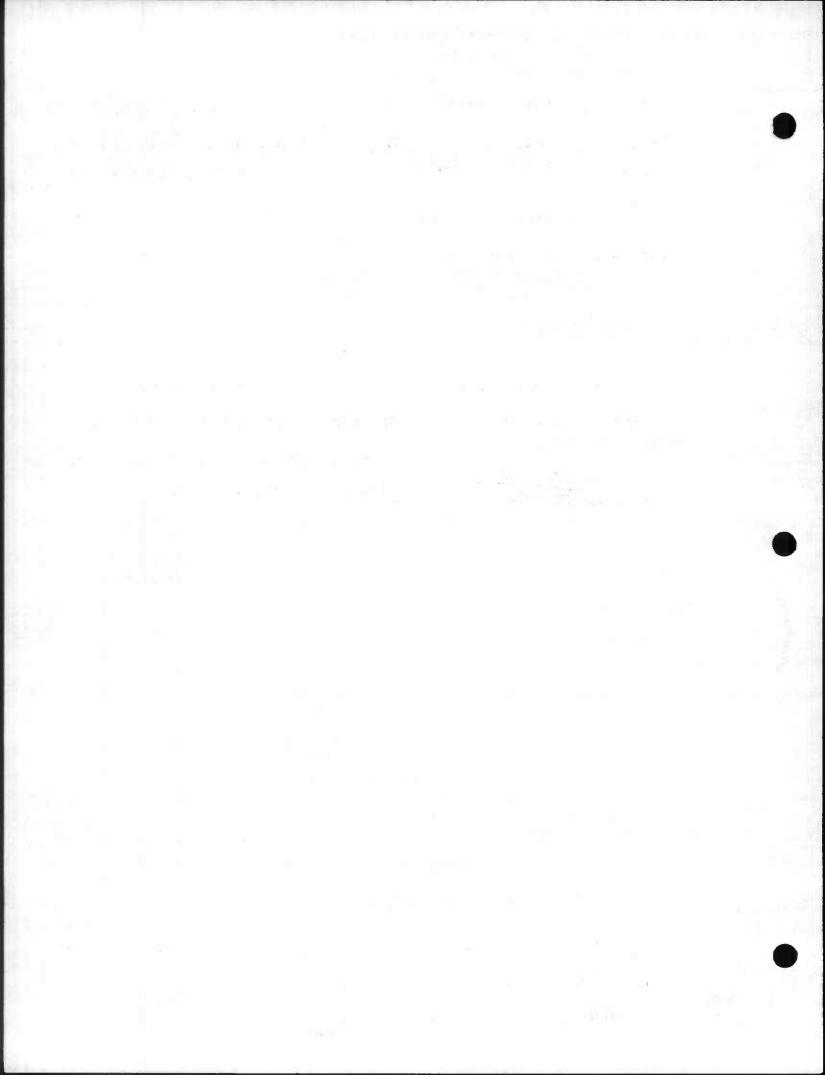
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State of Maryland / Department of Health and Mental Hygiene

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								Cert	ficate of	Death		eg. No.		
		Physici /Medi			ne (First, Middle, L HARD D	T.	ARLIN	G SR			2. Date of Deal Month MBKCV	Day	Year 99	3. Time of Death 0293
		Examir Funeral Director		5. Social Security 414-19	2Ster (- Number 6. -3742	Ve street and number	Hos ge (In yrs. las 37	OLTC t birthday) Yrs.	If Under 1 Year Months Days	Ab. City, Town, or Lo QUUDY If Under 24 Hrs. Hours Min.	8. Dilite of Birth /Month, Day MAY 3	Year) 61	9. Birthpla	Sten uce (State or Foreign ORIDA
	3	8 m		10a. State	10b. County		10c. City, 1	Town or Loca	tion				10	d. Inside City Limits
	5	28a-f sho notified at	tor	MD	DORC	HESTER	C	AMBRI	DGE					1 XYes 2□No
	-	or 28a-f	Directo	10e. Street and Nu	mber				10f. Zip Code		1	0g. Citizen of W	hat Countr	y7
	4	238		1607	STONE B	OUNDARY	ROAD		21	613		US	SA	
	d 21215-0020	if, or items	by Funeral	11. Meritel Stetus 1 Never Mar 3 Widowed	ried 2∏XMarried	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:	?		es Decedent of I es, specify Cub	Hispanic Origin? (Spe en, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		- America k, White, e	
	5-0	naturei'.		/Cna	15. Decedent's E	ducation		16a. Deceder	nt's Usuei Occup	pation		16b. Kind of Bu	siness/Indu	ustry
	Maryland 21215-0020	other than "r	Completed	Elementery/Sec 12		College (1-4or	5+)		E MANA				ARDW	ARE
	and	a da b	Be C		(First, Middle, Las	, KSON STA	RT.TNG			18. Mother's Neme		WOOD:	,	
0	aryla	DE E	10		eme/Reletionship			19b. Meiling	Address (Street	t end Number or Rura				Code)
7		27 is		CHRIST	INA STA	RLING/ w				E BOUND				
3	ore	2 2 2		20e. Method of Dis		Removel from State		e of Disposit	ion (Neme of tory or other ple	ce)	Dete	20c. Location - 0	City or Tow	m, Stete
7	altimore,	ant: If		4 Donetion	5 Other (Speci	Themovel from State	ST.	JOHN	STOWN	CEMETERY	3/20	/99 GI	REEN	WOOD, DE
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	the Hospi	in 24 hou the Funer ipletely fill	fedical	29e. Certifier (Check only one)	2 Medicai Exa	nysician: To the best miner: On the basis of end menner st	of examination	edge, deeth o n end/or inves	tigetion, In my o	opinion, deeth occurr	and due to the ca	ause(s) and mer ate end place, e	nner es ste ind due to t	ted. he ceuse(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** 17, Shockley 10:44 PM Helen Oliphant 1999 Marie March /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Wicomico Dagsboro Road 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months 1 M XCXF Yrs. Director 94 November 23, 1904 Wicomico County 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral JSA 14. Race - American Indian, 30367 Dagsboro Road 21804 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Domestic Housewife 18. Mother's Name (First, Middle, Maider 17. Father's Name (First, Middle, Last) Be 0 Edward Urie Oliphant Clara Ellen Showard 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30367 Dagsboro Road, Salisbury, MD 21804 ce of Disposition (Name of Date 20c. Location - City or Town, State Lavinia S. Hearn/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/22/99 Salisbury, MD Wicomico Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01051 Holloway Funeral Home, Professional Association brice 23a. Part1. Enter the disease, or complications hat caused the death. Do not anter the mode of dying, such as cardiac or faspiratory arrest, approximate shock, or heart feiture. List only one cause on each line. Interval Between Onset and Death MM-Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): gnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 9 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? Completed completion of ceusa of deeth? 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not ba determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be axec Division of Vital Records, P.O. Ne Hospital or Attending Pin 24 hours after death.

burial-tran and physician s the buria SBS esn ed by the datached signed by t page 2 : this funeral After t

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinet must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter c Department of Haalth and Mental Hygiene. Important: if item 27 is merked other than "natural", or iten any injury or other traumatic avant

Physician

/Medical

Examiner

altimore.

death

Medical To the To the To the I State

31. Date filed (Month, Dey, Yeer)

29b. Signeture and title of certifie

MAR 22 1999 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

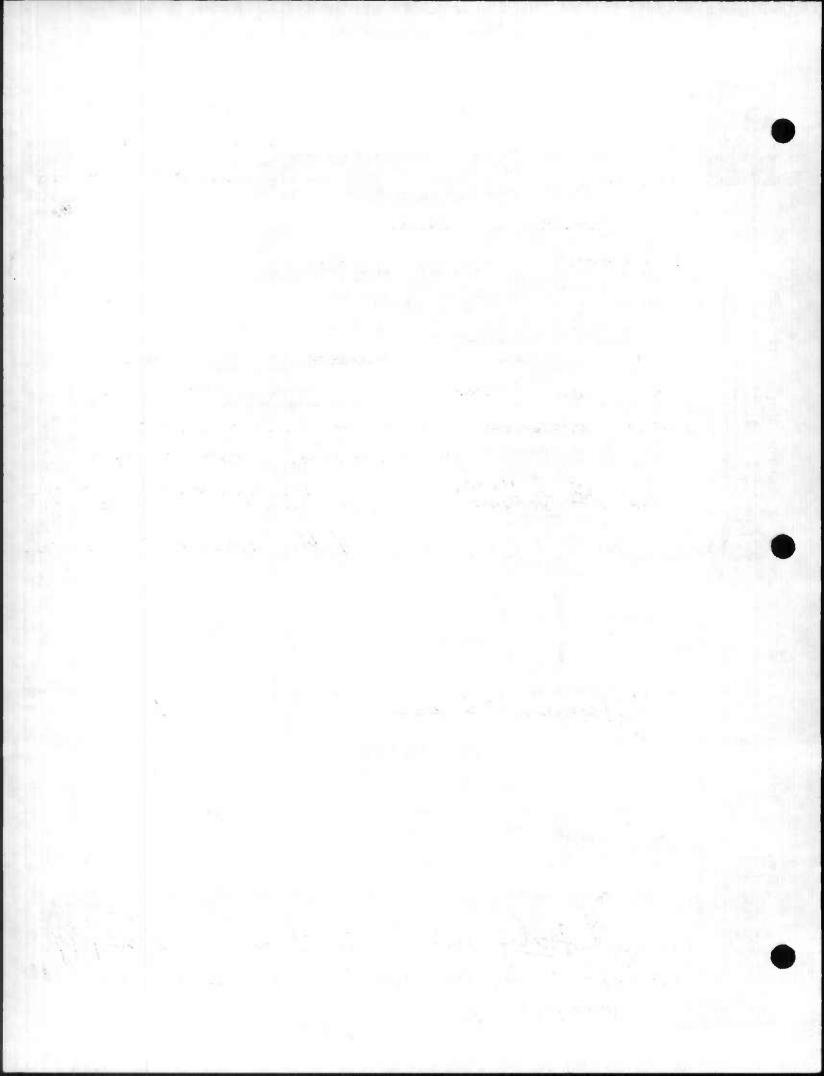
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dily,

Registrar

29a. Certifier (Check only one)



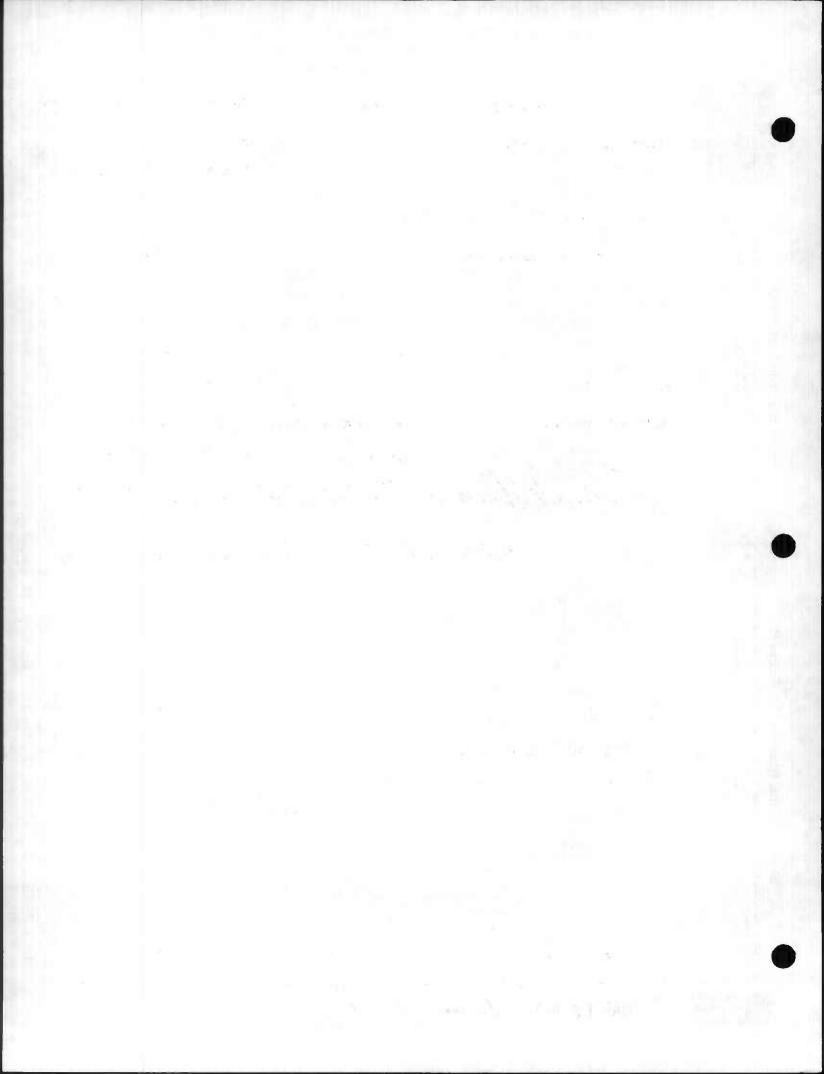
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

10587

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ysician Indian	ESTHER	M	ARGARET		SCHROEN		March	15 1	999	5:00 pm
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rai	. Sociel Security Nu	imber 6. Si	7. Age (Ir	yrs. last bir	Months D		Hrs. 8. Dete of Bir Min. (Month, De	y, Year) r 12,1904	9. Birthpi	ace (Stete or Foreign (ny) LIDOLS
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		Cremation 3 5 Other (Specify	Hemovel from State		dale Ceme		3/20/99	Washin	gton	, IL
	21. Signature of Fun		1 1		22. Name end A	ddress of Fecility		-	3 .	
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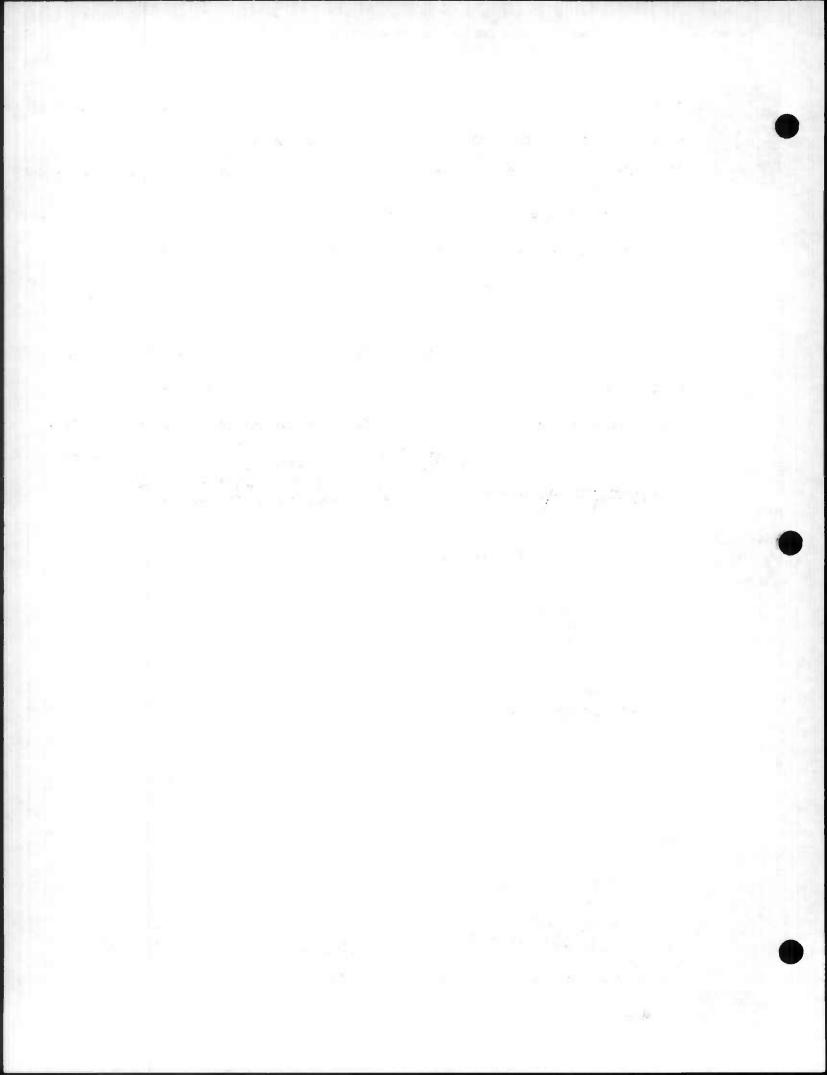
State of Maryland / Department of Health and Mental Hygiene

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ó	an ar		Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaasa or Injury		A 100 Page 1 A 200 Page 1 Page 1	3333C-16								- 3		
68760,	ysicia pe bu	edicai	(Hat minated evants	e	Due to (or as a	consequ	uence of):	_						-		
x 68	death certificate be axecuted to attending physician and ed for use as the buriel-transit	Med	resulting In death) Last	is.		T. Wilson								1		
Bo	2 5 3	an		d										-		
	the at	sici	Part II. Other significant conditions	contributing to death	but not rasulting i	n the un	derlying co	ausa giv	/an in Part I		23b. Dld	tobacc	use co	ntribute to	the cause	of death?
P.0	iras that tha death signed by tha atte d be detached for	/ Physician/	Ac a This	rid .							10	Yes	2 No	3 Pro	bably 4	Unknown
Records,	aw requisite been 2 should	Completed by									24a. Was perfo	an auto	opsy	av	ara autopsy allabla prior empletion of death?	to
	The i	E O									10	Yas 2	ONE !	10	□Yas 2□] No
of Vital		Be	25. Was casa rafarred to medical						28. Piace	of Deat	Check only o	na)				
>	Physician: this certific ral director,	5	axaminar?	Hospital: 1 ☐ Inpat	iant 2□ER/Oi	utpatient	3 DO	A Oth	ar: 49-Nu	rsing Ho	ma 5 Rask	dence	6 □Oth	er (Specif	(v)	
o uo	ith. After this e funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Panding 2 ☐ Accident Invastigation	28a. Data of In (Month, D	ury 28b.	Tima of Injury		8c. Injur Wor			28d. Dascribe I				,,	
Division	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicida 6 ☐ Could not be detarmined	26a. Place of it	njury - At homa, Is tc. (Specify)	arm, stra	aet, factory	, offica			281. Location (: City or Tox	Street a vn, Stat	nd Numb a)	er or Rur	il Route Nun	nber,
	Hospita 24 hours Funera letaly fille	edical	29a. Certifiar (Check only one) 1 Certifying Properties one)	nysician: To the best miner: On the basis and manner s	of axamination an	a, daath nd/or Inv	occurred a astigation,	at tha tir in my o	na, data an pinion, daa	d place, th occurr	and dua to the ed at tha tima,	causa(s data an	s) and ma id place,	nnar as s and dua to	tated. tha causa(s)
	Vithir To the	Me	29b. Signatura and titla of cartifig	11			29c	. Licens	e number			29d. Da	ata signe	(Month,	Day, Year)	
	F > F 0		1/1	14			1	2-	97	115	9	3	10	701		
			30. Nama and addrass of person who	completed source of	death (Item 02-1	/Tues !	Drint)		1)	7/		1	10/	11		
	10							C	ATTOR	עמוו	MD 210	0.7				
	Sta	ite	WILLIAM H. ROBINS 31. Date liled (Month, Day, Year)		04 HEAL'. rar's Signatura	LUMA	I DK.	. 5	ALISE	UKY,	MD 218	104				
	Sta Registr	-		999	eneva	G	1	lan-	1							

State of Maryland / Department of Health and Mental Hygiene

			otato of marytar	Certifica				g. No.	,	0589
Physic	ian	1. Decedent's Name (First, Middle, La					2. Date of Daath Month	Day Day	Year	3. Time of Death
/Medi	cai			hornton			March 2	_		2:00 PM
Examir	ner	4a. Facility Name (If not institution, given Calvert Manor He		r		4b. City, Town, or L Rising S		4c. County Cecil		
Funerai Director	Г	246-30-3949	Sex 7. Age (In yrs.	91 Yrs. If Und	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dev. Sept. 2:	Year) 2 1907	9. Birthpl County John	ace (State or Foreig try) SON Co., N
Aarylend f show	o	Usual Residence of Decedent 10a. Stata 10b. County DE New Cas		ty, Town or Location Imington					10	0d. Insida City Limit:
with the M 3e or 28a-	Funeral Director	10e. Street and Number 209 West Crest R		10f. Z	ip Code 1980:	3	10	g. Citizen of W USA	Vhat Coun	
o Z1Z13-UUZU filed within 72 hours after death with the Manylend hygiene. ther than "neturel", or items 236 or 28s-f show ont, the Medical Examinet must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, c	etc.
Mid yidilid AIX 15-0020 nd 2 should be filed within 72 hours aft the and Mantal Hygiene. It is marked other than "naturel", or traumatic event, the Medical Evant	Completed	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12)		16a. Decedent's Us (Give kind of w lifa. DO NOT Sales Lad		ation during most of work d)		6b. Kind of Bu		,
be filed had other svent, in	BeC	17. Father's Name (First, Middle, Last)		-	18. Mother's Nam	e (First, Middle, M			
should be nd Mental marked o	ToB	William H. Pittm	an			Tempie	L. Lanca	aster		
d 2 should the end Mer T is marks traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ss (Street	end Number or Rui	ral Route Number,	City or Town,	Stete, Zip	Code)
		Anne Grabowski -		209 W. C		Rd.,Carr				
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Wh	raca of Disposition (No cematary, cremetory or ite Clay C sbyterian	reek Chur	ch Cemete	3/25/99 2 ry	Oc.Location - Newark,		
permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licer		Spice	r-Mu	ssot Facility Llikin Fu Pont Pkw	neral Hor			720
Physician /Medicai		23a. Part1. Enter the disease, or com shock, or haart failure. List only Immediate Cause (Final				ng, such as cardiac	or respiratory arres	st,		Approximate Interval Betwean Onset and Death
Examiner		disease or condition rasulting in death)		rtery Dise						
D #	iner		h		,					
and I-trens	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (c	or as a consequence of	f):					
rtificata be executed ng physician and set the burial-transit	edicai E	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last	cDue to (c	r as a consequence of):					
deeth certific e attending p	Physician/Me		d							
• 0 00	sici	Part II. Other significant conditions of	ontributing to death but not res	ulting In the underlying	cause giv	an in Part i.	23b. Did tob	acco use con	tributa to	the cause of death
as that the deeth cer igned by the attendin be datached for usa	by Phy	Complete Hear	t Block				1 🗆 Ye	2 2 No	3□ Prob	ably 4 Unknow
aw requir	Completed						24a. Was an perform		ava	re autopsy findings ilable prior to apletion of cause eath?
							1 ☐ Yes	2 0 No	1 🗆	l Yes 2□ No
Physician: The	Be	25. Was case rafarrad to medical examiner?	Hospital:		Oth	or:	h (Check only one			
	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ E 28b. Time of	JUA	4 M Nursing Ho	me 5 Resident)
l or Attanding after death. Director: After d in by the fune	Certification:	1 Natural 5 Panding 2 Accident investigation 3 Sulcide 6 Could not b	(Month, Dey Year)	М		Yas 2 □ No				20.4.4.4
To the Hospital or Attanding Phys within 24 hours after death. To the Euneral Director: After this completely filled in by the tuneral di		4 Homicide datarmined	building, etc. (Spacil	y)			28f. Location (Stre City or Town,	Stete)		
n 24 h	edical		ysician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or Invastigatio	on, in my o	pinion, death occur	and due to the cau red at tha tima, dat	usa(s) and mai a and place, a	nner as sta ind due to	ated. tha causa(s)
To the To the Comp	Me	29b. Signature and title of the land	apriles	2	9c. Licens	e number 15344	29	d. Date signed	Month, L	Dey, Yeer)
		30. Name and addrass of person who Suresh Dhanjani					MD 2190	03	1 '	
Sta	ite	31. Date filed (Month, Dey, Year)	32. Registrar's Signa	ture 4	. V. 1			_		



State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate o	f Death	F	leg. No.	e al	10000		
Г	B1		1. Decedent's Name (First, Middla,	Last)			III-LE		2. Date of Dea	th	120	3. Time of Death		
	Physic /Medi		WILLIAM		I.		TE	EL	MANCH	Day 17/4	799	10:53		
4	Exami		4a. Facility Name (If not institution,	give straat and number)				4b. City, Town,	or Location of Death	4c. County		70. 50		
			UNIV. OF MA	RYLAND	MEL	ICAL	System	BAL	HIMORE	1	1/4			
	Funeral	100		. Sex 7. Ag		est birthday,	If Under 1 Ya	ar If Undar 24 h		1	9. Birthp	lace (Stete or Foreign		
	Director		180-05-2328	1 AM 2□ F	89	Yrs.	Months Day	s Hours N	lrs. 8. Date of Birth lin. (Month, Day March 20	1909	Virg			
	P.		Usual Residance of Decedent											
	show	_	10a. State 10b. County		10c. City	, Town or L	ocation				1	0d. Insida City Limits		
	e Ma	cto	Pennsylvania Che	ster	Ke	nnett	Square					1 Yas 2 □ No		
	or 28	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of	What Cour	itry?		
	within 72 hours efter death with the Maryland iene. 'than "natural", or Items 23a or 28e-f show the Med cal Exeminer must be notified at		636 Linden Circl	.e			19	348		United	State	25		
	e me	Funerai	11. Marital Status	12. Was Dacedent Armed Forces?	Ever in U,S	3. 13.	Was Decedent o	f Hispanic Origin?	(Specify Yas or No- arto Rican, etc.)	14. Rad	e - Americ	an Indian,		
0	or it	正	1 Never Married 2 Married				1□ Yes 2 N		ano moan, etc./					
200	ours	d by	3 ⊠NWidowed 4 □ Divorcad	Year or Dates:			10 165 2014	о орвану.		Specif	Whi	te		
21215-0020	72 h matu	Completed	15. Decedant's (Specify only highast of	Education arede complated)		16a. Dece	dent's Usual Occ	upation e during most of	vorkina	16b. Kind of B	usiness/Ind	dustry		
121	within ene.	ig.	Elamantary/Secondary (0-12)	College (1-4or	5+)			ne during most of tred)		T) * (7 ~~~	culture		
		S	8			Nurse	ery Man					Culture		
Maryland		Be	17. Fathar's Nama (First, Middle, La	st)				18. Mothar's h	lame (First, Middle, i	Maiden Surnen	na)			
yla	s should be and Mentel s marked o	2	James G. Teel						Wimmer					
lar			19a. Informant's Name/Relationship	(Type, Print)		19b. Maili 636	ing Address (Stra	at and Number or	Rural Route Number ennett Sq	r, City or Town,	Stete, Zip	Coda)		
	is 1 and 2 should of Health and Mer item 27 is marks other traumatic		William H. Teel/	Son		Penns	sylvania	19348	cimett bq	uare,				
ore	t of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3	Demoval from State	20b. Pla	ace of Dispo matary, cre	osition (Neme of metory or other p	laca)	March 20	20c. Location -	City or To	wn, Stata		
E	@ C = >		Penr	nsylvania										
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funaral Servica Lic	Signature of Funaral Servica Licensea 22. Nama and Address of Facility Hicks Home for Funerals, P.A.										
m	88 5 8		Man	2 1		110	icks Hom 03 West	e for Fu Stockton	nerals, P Street,E	.A. lkton M	arvla	nd 21921		
	THE R		23a. Part1. Enter the disease, or co shock, or haart failure. List on	mplications that caused	tha daath.						ary re	Approximate		
	Physician		SHOOK, OF HEART TERRORS. LIST OF	y one cause on each ii	na.						H	Intarval Between Onsat and Death		
	/Medical		Immediate Cause (Final disease or condition	Runt	14.1	Link	E TO	ALLIA	11	/ www	EXAMINER	1 DAY		
	Examiner	9.1	resulting in death)	BLUNT	Dua to (or	as a consa	duance off.	7	ALL PROVE	D BY MEDICAL	-	1 01.9		
_	D #	ner		b. LEPT	•			✓ GE	MITTICAL ON APPROVE			541		
	eath certificate be executed ettending physician and for use es the buriel-transit	Examiner	Sequentially list conditions.	b. CC1 (Due to (or	as a consec	guence of):					DAY		
ó	an al		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury	BilAti	DAI			LAI T	PACIAL	Fort	1144	200		
68760,	ysici	edicai	that Initiated events rasulting in death) Last	6.01 CATO	Dua to (or a	as a consac		THE II	TACIFIC	Inaci	wes	DAY		
99	ng pt	Med	rasulting in daatii) Last	100	MIA	Vict		2AC+L	06					
XO	endir r use	Sie		d. Let		VICE	-6 11	CACTU	RC		/	DAY		
B.	0 0 2	Physician	Part II. Other algnificant conditions	contributing to death b	ut not resul	ting In the u	indarlying cause	aiven in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?		
0.0	by the	hy							1 🗆 Y	2 No	3 ☐ Prot	pably 4 Unknown		
S,		by F							_	74				
									24a. Was a		24b. We	ere autopsy findings ailable prior to		
ecord	- A 0	plet							perform	1160 /	COI	mpletion of cause death?		
α	0 - 0	Completed							1 U Y	as 20 No				
Vital		Be C	25. Was case referred to medical					26 Place of F			1	Yes 2□No		
		0	exammer? 1 2 Yes 2 □ No	Hospital: 1 XInpatie	nt 2DE	R/Outpatier	nt 3 DOA	ther:	eath (Check only on		ar (Casait	.1		
ō	문부	1	27. Manner of Death	28a. Date of Inju		28b. Time of	f 28c. In	ury at	Home 5 Reside			9		
0	Attending For death. Sctor: After by the funer	tio	1 □ Natural 5 □ Panding 2 Paccident investigati	on > //-	C Q	Injury	W	ork? □ Yes 2 No				OBACH		
18	Attender death ector:	fica	3 Suicide 6 Could not	ba 390 Place of Inci	ury - At hor	07.36 ne. farm. str	reet, factory, offic		MotoR 28f. Location (St					
Division		Certification	4 ☐ Homicide determine	building, et	. (Spacify)		,, 0110		City or Town	, Stete)				
	Hospital or 24 hours efter Funeral Dir stely filled in		29a. Certifier Certifying F	hysician: To the best of	1 W A		h occurred at the	time date and ale	CECIL C	ounty	R+. 4			
	o the Hospital or vithin 24 hours effe o the Funeral Dir ompletely filled in	edical	(Check only one) 2 Medical Exe	miner: On the besis of and manner sta	examination	on and/or In	vestigation, in my	opinion, death oc	curred at the time, d	ate and place,	and due to	the cause(s)		
	within 2 To the	Me	29b. Signature and title of cartifier				29c. Lice	nse numbar	2	9d. Date signe	d (Month, i	Dey, Yeer)		
	F > F O									_				

State Registrar

31. Data filad (Month, Day, Year) MAR 2 2 1999

Willianc. Chin, M.D.

30. Nama and address of person who completed causa of death (Item 23a) (Typa, Print)

(Type, Print) D 4 6 147 MARCH 17, 1999 22 South GREEN St. BALLIMORE MD 21046 32. Ragistrar's Signatura

DHMH 16 Rev 6/95

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** MARILYN LOUISE UHLER March 7:00 a.m. 23 1999 /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Chesapeake Beach 4575 Willows Road Calvert If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1 □ M 2 🛛 F Yrs. 163 22 0801 70 July 27, 1928 Pennsylvania Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No Chesapeake Beach Calvert Maryland Director 10e. Street and Numbar 10f. Zlo Coda 10g. Citizan of What Country? 4575 Willows Road 20732 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Raca - Amarican Indian, Black, Whita, atc. ☐ Yas 2 No f Yas, Giva 1 Nevar Marriad 2 Marriad 1□ Yas 2√2 No Specify: by 3 Widowad 4 Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) homemaker own home 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) e Adelaide Thomas Owens Dorothy 2 19a. Informant's Name/Reletionship (Typa, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) same as # 10 above Robert B. Uhler, husband 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Bunal 2 🂢 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3-24-99 Alexandria, VA 21. Signatura of Funarai Sarvica Licansea 22. Nama and Addrass of Facility Rausch Funeral Home, P.A., Owings, MD 20736 Oceans -23a. Part 1. Entar tha disaasa, or cor p cations that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart feilura. List of ly o le causa on aach lina. Approximata Intarval Batween Onsat and Death Obstructive Pulmonary Disease Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, laading to Immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? t Pres 2 □ No 3 □ Probably 4 □ Unknown þ 24b. Wara autopsy findings Completed 24a. Was an autopsy available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes casa rafarrad to medical 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) P 28c. Injury at Work? Certification: 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 1 Maturel 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 THomicide 1 Cartifying Phyalcian: To the best of my knowledga, daath occurred at the time, deta and placa, and dua to the cause(s) and mannar as stated.

2 Madical Examinar: On the basia of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29a. Cartifian Medicai (Check only one) 29b. Signatura and titia of certified 29c. Licansa number 29d. Data signad (Month, Day, Year) D16823

10 State Registrar

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mark be nothed at

"natural", or items

permit. Pages 1 end 2 should be filed within 7. Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Media Once.

Physician

/Medical Examiner

attending physician end for use es the buriei-transit certificate be executed

the

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peed

certificata

this

After t

n 24 hours after death.

Ne Funeral Director: After pletely lilled in by the fur

To the Hospital or Attending I within 24 hours aftar death.

To the Funeral Director: After

page 2 has

Box 68760.

Division of Vital Records, P.O.

filed within 72 hours efter Hygiene.

Saltimore, Maryland 21215-0020

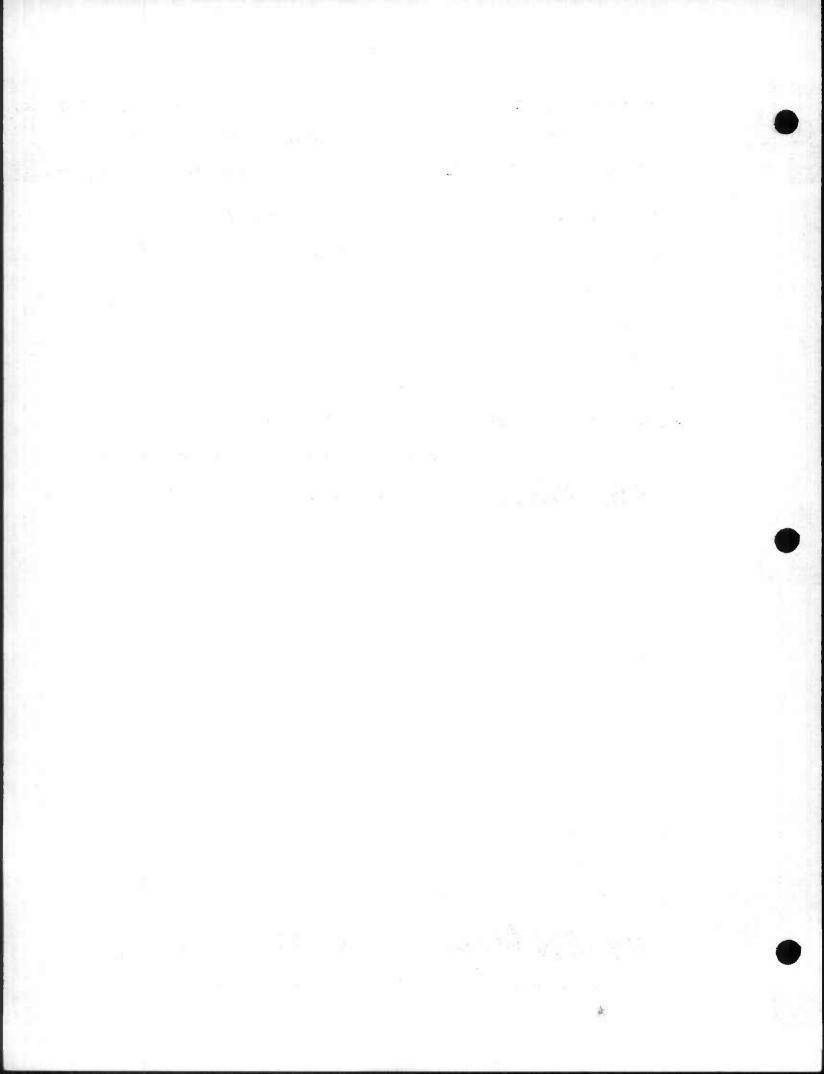
the Maryland

Robert J. Schlager, M.D.

30. Nama and addrass of person who complated cause of death (Item 23e) (Type, Print)

Prince Frederick, MD 20678

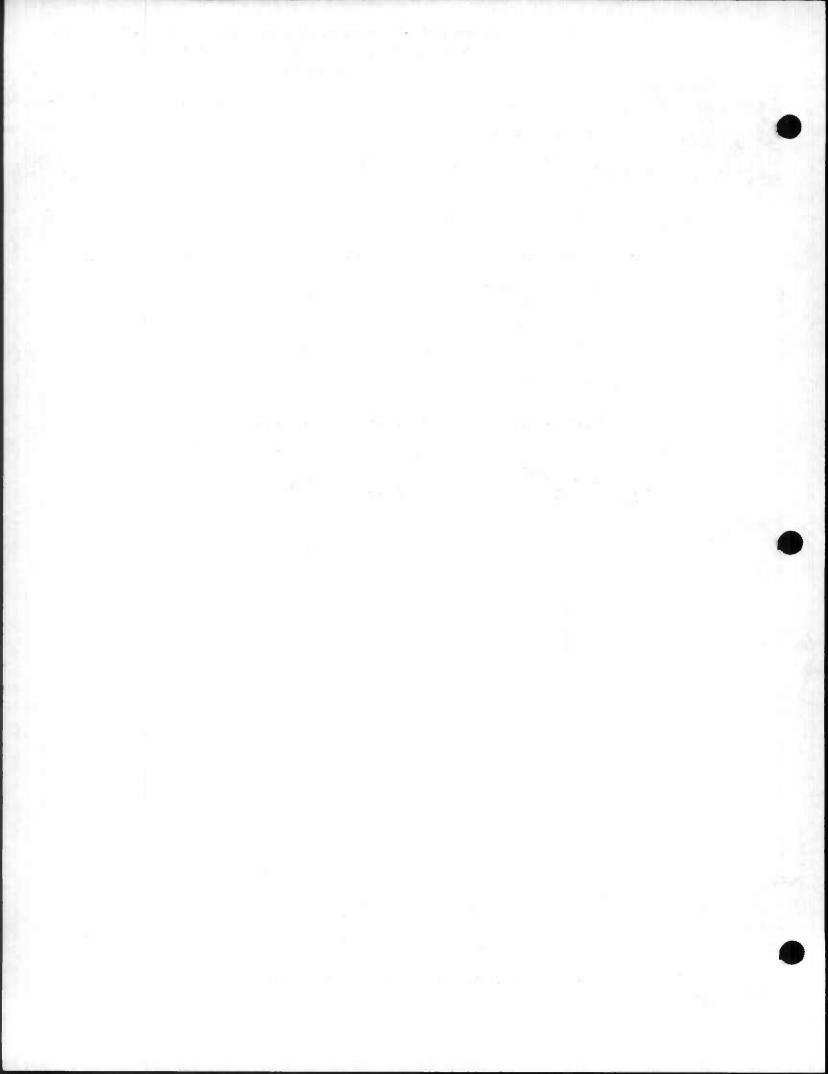
31. Data filed (Month, Day, Year) 32. Registrar's Signatura MAR 2 Deneva



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			State of Mary		artment of I		R	leg. No.	9	10592	
Physic /Medi		1. Decedent's Neme (First, Middle, Las James Alexande	er Warren,	Sr.			2. Dete of Dee Month March	_	993	3. Time of Death 12:58pm	
Exami	ner	4e. Fecility Neme (If not institution, give CIVISTA MEI	street end number) DICAL CENTER	2		4b. City, Town, or LAPLA	Location of Death TA	4c. County	of Deeth CHARL	ES	
Funeral Director		212-14-0400	Dat 600 5	yrs. last birthday) 83 Yrs.	If Under 1 Yeer Months Days			Year) 1915	9. Birthpi Count Mar	ece (Stete or Foraig try) yland	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Charles		c. City, Town or Lo					10	od. Inside City Limits	
or 28a	Directo	10e. Street end Number			10f, Zip Code		10g. Citizen of Whet Country?				
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiena. It has not seen as a conserved other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner trust ten notified at	by Funeral	Annapolis Woods 11. Marital Status 1 Never Married Marriad 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 (X) No If Yes, Give Yaer or Datas:	1	U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 13. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 14. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 14. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) Yes 2\(\text{Yes} \) No \(Specify: \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 15. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien, Bleck, White, etc. 1 \(\text{Yes} \) 10. Rece - American Indien,						
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ould be filed with Mental Hygiena. arked other than atic event, me	To Be Co	17. Fathar's Nama (First, Middle, Last) Yellie Yancy Wa	arren	Dus	Contrac	18. Mother's Na	Board of Education or Name (First, Middle, Maiden Surname) a. E. Ross				
Pages 1 and 2 should I nent of Health and Meni int: If itam 27 is marked ury or other traumatic o	_	19e. Informent's Name/Relationship (7) Alice C. Warrer 20e. Method of Disposition 1 Naurial 2 Cremetion 3 Di	n/Wife Ramoval from Stata	P.O. Ob. Plece of Dispo	Box 46 sition (Name of netory or other pla	Welcon	1 26, 19	land 2 20c. Location -	20693 City or To	3 wn, Stete	
permit. Page Department or Important: If i any Injury or 2009.		4 Donetion 5 Other (Specify 21. Signature of Funerel Service Licen	1 10	Zion Ba W W	Name and Addre	ess of Fecility Funera	al Home,	P.A.		aryland 20640 d,Maryla	
Physician /Medical Examiner payman ag sys	al Examiner	23a. Pert1. Entar the clease, or compshock, or heer clum. List only commediate Ceusa (Final disease or condition resulting In deeth) Sequentlelly list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury	e. CONE	ESTIV	UE (uenca of):	HEA		AILUR	€	Approximate intervel Between Onset end Deeth	
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has b	Completed t						24e. Wes e perfor	med?	ave cor of c	ere eutopsy findings ailabla prior to inpletion of cause deeth?	
	Be Co	25. Was casa referred to medical				26. Piece of De	eeth (Check only or	1		1162 20140	
Physician: this certific ral director,	ToE	TU Tes ZEDINO		2 ER/Outpetien	t 3L DOA		Home 5 ☐ Resid			1)	
Aller Aller	Certification:	27. Manner of Deeth Networei S Pending 2 Accidant Investigation 3 Skicide 4 Homilcide Homilcide	28e. Dete of injury (Month, Dey Yea 28e. Piece of Injury building, etc. (S)	ny et ork?] Yes 2 ☐ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Hospital 24 hours Funeral tely filled	edical Ce	29a. Certifier (Check only one)	sfcian: To the best of my fner: On the bests of exer end menner steted.	r knowledge, deeth mination end/or Inv	occurred et the ti vastigation, in my	ime, dete end plec opinion, death occ	e, end due to the curred at the tima, d	euse(s) end me lata and place,	enner es st and dua to	eted. tha causa(s)	
To the To the comple	Me	29b. Signeture end title of certifier **Example 1.5	7. Man	m-	29c. Licen: D=2	se number 28352	2	29d. Date signed (<i>Month</i> , <i>Dey</i> , <i>Yeer</i>) 3 – 2 1 – 9 9			
		30. Neme and address of person who co Krishan M. Mathu	ompleted cause of deeth	(Item 23e) (Type, nbridge F	Print) Prof. Ctr	. Suite	102 Wal	dorf, M	D 20	0602	
Sta	ite	31. Date filed (Month, Dey, Year)	32. Registrar's S	Signature	1 1		_				



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1999 **Physician** MARCH 189 MAURICE F. WHITCOMB 2:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner ALLEGANY COUNTY NURSING HOME CUMBERLAND ALLEGANY 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stele or Foreign Country) SEPT 9, 1920 MASSACHUSETTS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdev) **Funeral** 1**▼**M 2□ F Months Deys Hours Yrs. 020-12-3208 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or lients 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND ALLEGANY CUMBERLAND Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 12918 N. CRESAP ST. APT 50 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. hours after 1X Yes 2 No If Yes, Give WW Yeer or Dates: 1 Never Married 2 M Merried Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry should be filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT CONTRACT ESTIMATOR 12 is marked other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) and Mental MAURICE PILLSBURY WHITCOMB GLADYS JANES DAY 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is n 12918 N. CRESAP ST. APT50, CUMBERLAND, MD 21502 DOROTHY M. WHITCOMB/WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State SILBAUGH CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 19,1999 UNIONTOWN, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility amy i HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 Dugas & 23a. Pert1. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart last re. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical 2 YRS Examiner Examiner end i-transit Tha lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): attanding physician e Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of) P.O. ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evalleble prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peen s has a 2 2 No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) After thi funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28h Time of 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 ONatural 1 Yes 2 No To the Hospital or Attendit within 24 hours after deeth.
To the Funeral Director: All completely filled in by the fu deeth. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. (Check only one)

Mes

State Registrar

31. Date filed (Month, Dey, Year) MAR 1 9 1999

Jany

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture end title of certifier

BARRERA MO 32. Registrer's Signeture

CUMBERLAND.

29c. License number

0-14865

M1).

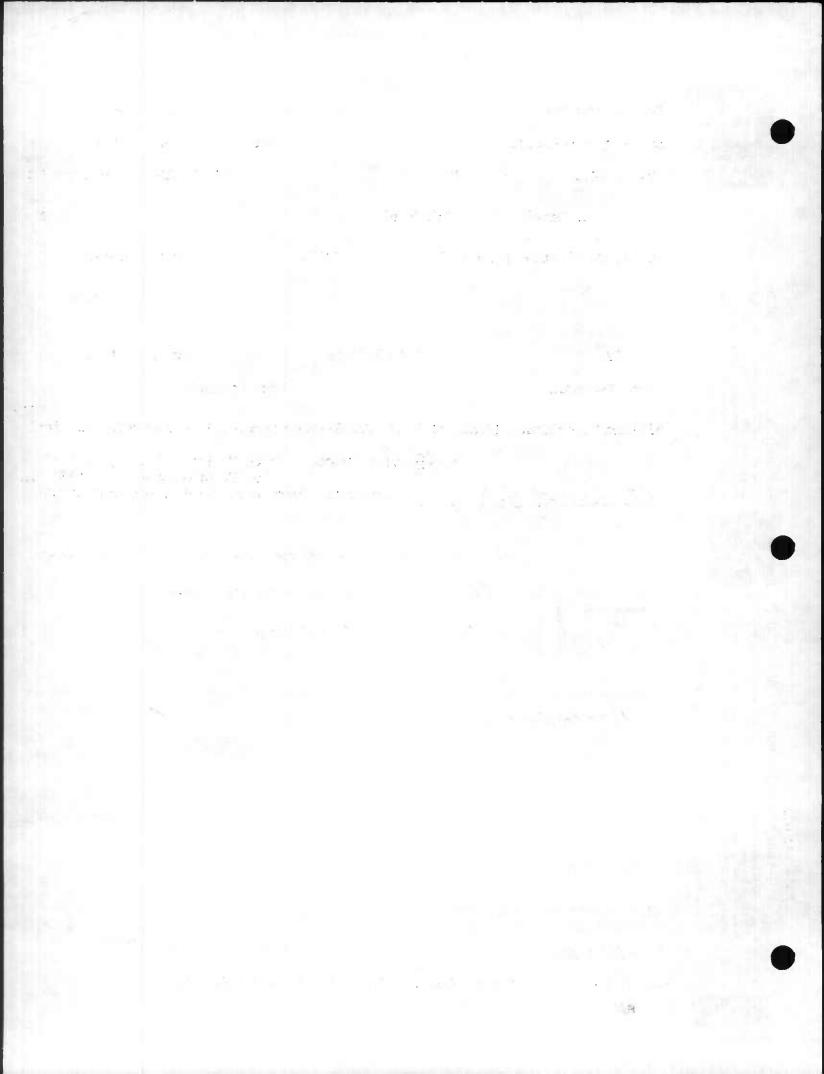
29d. Date signed (Month, Day, Year)

21502

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5 9 4 State of Maryland / Department of Health and Mental Hydiene

MD St. Mary's California Interest		1.	. Decedent'a Nam	ne (First, Middl	le, Last)	Total III			rtificate of			Date of Dea			3. Time o	of Death	
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MD St. Mary's California 10/2 code 20/2 code				1										7			
109. Street and Number 23140 Cobblestone Lane #301 20159 United States 23140 Cobblestone Lane #301 20169 United States 11. Martial Sianus 12. When Developin Ever in U.S. 12. When Developin Chiefer, Mexican, Public Rise, and the Private Part of Rises. White, etc. 25. Specify: White Specify Chiefer, Mexican, Public Rises, American today, Plant of Rises, American today, Plant of Rises, American today, Plant of Rises, Mexican, Public Rises, White, etc. 25. Specify: White Specify of the Public Rises, White, etc. 25. Specify: White Coloration (Glove Rises of Specify Chiefer, Mexican, Plant Rises, American today, Plant Rises, American Rises, Amer								1					10d. Inside City Li				
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Marco Leonardi 19th Maling Address (Street and Number or Bural Route Number, City or Town, Stele, Zp Code)			1	2				Retai	il Clerk	1					Store		
Marco Leonard: 19a. Informant's NamePleationship ("Type, Pint) 19b. Maling Address (Street and Number or Rural Route Number, City or Town, Siete, Zip Code) William H. Waidman (Husband) 23140 Cobblestone Lane, #301, California, Maryla 20b. Report of Date (Specify) 20b. Flace of Disposition (Name of contributing to General From State of Date (Specify)) 21c. Signature of Tuneral Service Licensee 22c. Peart Enter the disease, or complications that caused for death. Do not enter the mode of dying, such as cardiac or respiretory errest. 22a. Peart Enter the disease, or complications that caused for death. Do not enter the mode of dying, such as cardiac or respiretory errest. 22a. Peart Enter the disease, or complications that caused for death. Do not enter the mode of dying, such as cardiac or respiretory errest. 22b. Super signature of Underlying and Cardia (Check only one cause or each first.) 25c. Viv. Lange Fried Indestrying Cause (Disease or frilluy) 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner. 25c. Was case referred to medical e	0	1												ne)			
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2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)	Be Completed by Physician/Medical	d ri	disease or condition esulting in death) Sequentially list contains any, leading to interest any, leading to interest easier. Enter Undeate, (Disease or nat initiated events esulting in death) I leart II. Other elignif	onditions, mediate artying injury s Last	b c d ons contributin	A CU Se	Due to (or	r as a consequence of the conseq	quence of): Legal property in the control of the c	fr) my	F= (3);	23b. Did t 1 1 Y	tobecco use co Yes 2 No	ntribute to 3 Prot	Intervel Be Onset and Onse	of deat Unkno	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIRAN MEHTA M.D. PHILIP J.BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636	edical Certification: To Be Completed by Physician/Medical	Sit occurrence of the control occurrence occ	disease or condition esulting in death) Sequentially list color any, leading to include a cause (Disease or nat inflated events esulting in death) I art II. Other significant and II. Other significan	onditions, mediate strying injury s. Last ficant conditions. The conditions of the	d	ali: 180 Inpatie Date of Inju (Month, De Place of Inju building, etc To the best on the basis of	Due to (or All purity of my know of exeminatial ated.	es e consequence de la consequence de la consequence de consequence de la consequence del consequence de la consequence del consequence de la consequence del consequence de la consequence del consequence del consequence del consequence del consequence del consequence del consequenc	nuence of): Juence of): Juenc	26. Place of ther: 4 \(\) Nursury at ork? \(\) Yes 2 \(\) No time, date end opinion, death onse number	o 28f.	23b. Did t 1 1 Y 24e. Wes perior 1 Describe h Location (SC) or Tow	cobecco use co Yes 2 No en eutopsy med? Yes 2 No ene) dence 6 □Oth now Injury occur Street end Numb m, Stele) ceuse(s) end mi date and place,	anner es st and due to	intervel Be Onset and Onse	of deat Unkno	



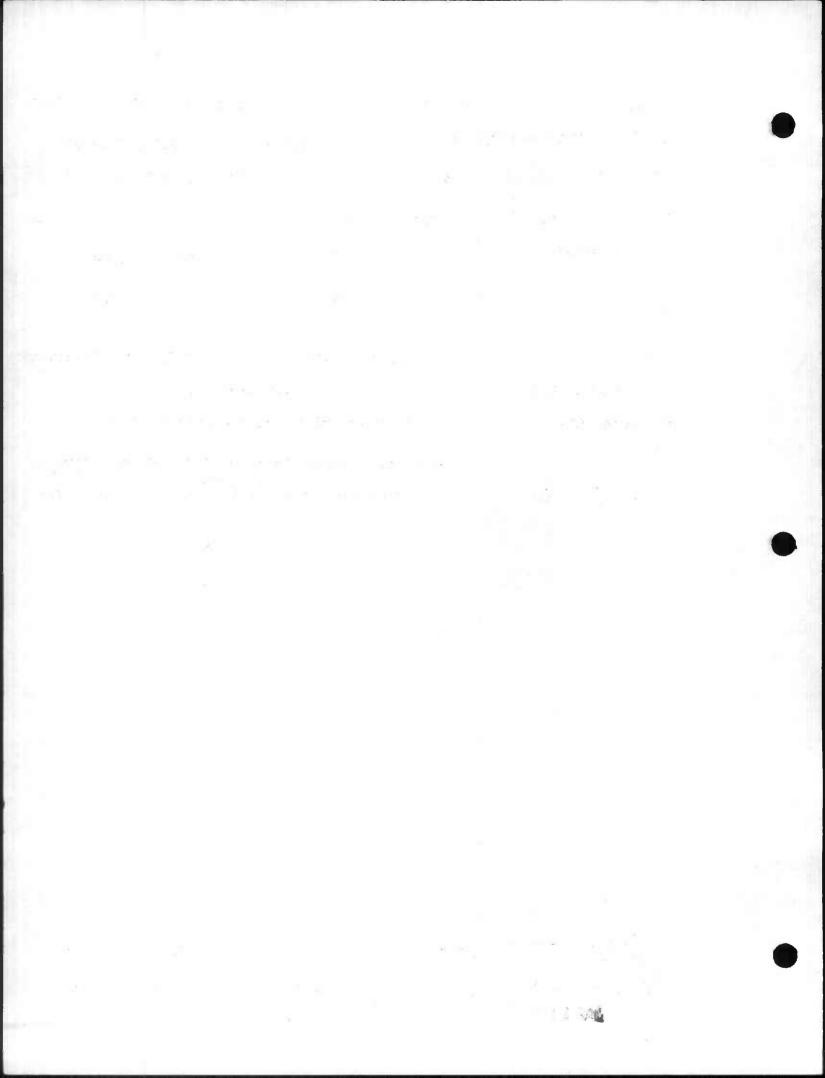
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Physician	771	В	Wise		March	17, 1999 ear	8:05 AM
/Medical Examiner	4 - Facility Nieura (March 1 alternation 1		WISC	4b. City, Town, or Lo			
CABITITIES		nty Nursing Ha	me	LaPlata		Charles	
Funeral	5. Social Security Number 6. S		last birthday) If Under 1 Yeer	If Under 24 Hrs.	8. Dete of Birt		npleca (State or Foreign
Director	579 09 6264	□ M 20 F	Yrs. Months Days	Hours Min.	(Month, Da)	7, Year 1900 9. Birth Con	intry)
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h the Marylen r 28a-f show Incurred at	10e. State 10b. County		y, Town or Location				10d. Inside City Limits
Mar Mar	Maryland Prince G	eorge's	Clinton				1 ☐ Yes 2000
deeth with the Maryland me 23s or 28s-f show Linual be notified at	10e. Street end Number 8600 Mike Shapi	ro Drive #913	10f. Zip Code 2073	35		10g. Citizen of What Co.	untry?
deeth	11. Meritai Status	12. Was Decedent Ever In U.	S 13 Was Decedent of	Hispanic Orlain? (Spe	oify Yes or No		ican Indian
s after	1 Never Merried 2 Merried 3 Nover Merried 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	S. 13. Was Decedent of if Yes, specify Cut		Rican, etc.)	Black, White Specify: Wh	, etc.
5-00, 72 houn natural, deal Ex			16a. Decedent's Usual Occu	petion		16b. Kind of Business/I	nduetor
ind 21215-0 be filed within 72 ho tel Hygiene. overt, the Medical	(Specify only highest gre	de completed)	(Give kind of work done life. DO NOT use retin	during most of worki	ng	TOD. TAIL OF DUSINGSOF	ridustry
d withir r than	Elementery/Secondary (0-12)	College (1-4or 5+) N/A	Switchboard			Apartment	House
D Hand	17. Father's Name (First, Middle, Last,		DWICCIDOCIA	18. Mother's Name	(First, Middle,		nouse
d be and	Harry Burkholder			Lou		Hollaway	
Maryland 2: 12 should be filed w 12 should be filed w n and Mentel Hygier I's merked other u reumetic event, th To Be Co	19e. Informent's Name/Relationship (19b. Mailing Address (Stree				in Code)
Ma d 2 s th en 7 ls t	Luther C. Wise	** *				dywine, MD	
Heeling 2	20a. Method of Disposition		lace of Disposition (Name of	1071121212	Date		
or of Hith	1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	emetery, cremetory or other pla			20c. Location - City or 1	
Baltimore, Maryland : permit. Pages 1 end 2 should be filed Department of Heelth and Mentel Hyd important: if flem 27 is marked other any Injury or other traumatic event, once. To Be C			e Crematory			Clinton, Ma	
Bal Departimon Importing	21. Signature of Furthers Stay the Licer	Sae //				al Home, In	
m 89539	· //lika/	Lu	6633 Old	Alexandri	a Ferry	Road Clint	on, MD 2073
Physician /Medical Examiner	23a. Part1. Enter the disease, or com- shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)		like Jail ras a consequence of: Crivialte				Approximate Interval Between Onset and Deeth Week. Type au
P.O. Box 68760, let the death certificate be executed by the ettending physician and etached for use as the burial-transit Physician/Medical Examiner	Cause (Disease or Injury thet initieted events resulting In death) Last	C	r es e consequence of):				
death death ad for u	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underiving cause o	iven in Part I.	23b. Did t	obacco use contribute	to the cause of death?
					101		obably 4 Unknown
v requir					24a. Was perfo	med? a	Vere autopsy findings vallable prior to ompletion of cause f deeth?
The tree house					1 🗆 Y	es 2DNo 1	☐ Yes 2 No
Vital Re- victen: The lay certificate hes rector, page 2	25. Was case referred to medical			26. Place of Death	(Check only o	ne)	
of Vital Re- Physician: The lav This certificate hes ral director, page 2		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	her: 412 Nursing Ho	ne 5□Resid	ence 6 Other (Spec	ify)
g Physer this seral di		28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo			ow Injury occurred	,,
Division of the or Attending P to a steer death. al Director: After to death by the funerated in by the funerated in the fun	1 ☐Naturel 5 ☐ Pending 2 ☐ Accident investigation			Yes 2□No			
Divisio or Attendi after death. Director: A i in by the fi	3 ☐ Suicide 6 ☐ Could not be determined	286. Placa of Injury - At no	me, farm, street, factory, office			treet and Number or Ru	ral Route Number,
d Date of D	4 Homicide	building, etc. (Specify)	2	City or Tow	n, State)	
Division or To the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7		ysician: To the best of my knov liner: On the basis of examinat end manner stated.	viedge, death occurred at the tion and/or investigation, in my	ime, date and place, a opinion, death occurre	and due to the ded at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
of the omple		one marrier states.	29c. Licen	se number		29d. Date signed (Month	, Dev. Year)
F 3 F 8	2000		DO	67m	4	3-18-	99
	per	rous	00	610	/	- 10	(/
4	30. Name and address of person who	completed cause of death (Item	4GE LAPLA	TA MO	2064	4	
T.	31. Date filed (Month, Day, Year)			474 673			
State Registrar	MAR 1 9 1999	32. Registrar's Signat	9. Some	,			

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State of Maryland / Department of Health and Mental Hygiene

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							Cei	tificate c	f Death		Reg. No.			
	siciar	_	1. Decedant's Nama (Firs Helen			Vagner				2. Date of Ma.K.Ch	Death	1999 ^{Yae}		ima of Daath :57A.M.
	edica mine	_	4e. Fecility Name (If not in Southern		e streat and number) and Hospti	lal			4b. City, Town,	or Location of Da	- 1	county of De		210
Fune Direct	_		5. Social Security Numbe 579 14 401 Usual Rasidance of Dece	7 1	Sex 7. Ag	a (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24	Hrs. 8. Data of (Month,	Birth Day, Yaar)	9. E		State or Foraign
anylend	١,	_		County			Town or Lo							side City Limits
the M 28a-f		200	MD 10e. Straat and Number	P.G		Ca	mp sp	rings			10 000			Yas 2 No
23a or	2	runeral Director	5203 Oahu	Court				10f. Zip Cod 2074			United States			
ges 1 and 2 should be filed within 72 hours efter death with the Maryland tof Heelth and Mental Hyglene. If I lear 27 le marked other than "natural", or thems 23a or 28a-f ahow or other thatmatic event, the Medical Examine must be notified.	hy G	2	11. Meritel Stetus 1 □ Navar Merried 2 3 ☑ Widowad 4 □ □		12. Was Decedant Armed Forcas? 1 Yas 2 Yes, Give Yeer or Datas:			Was Decedant of Yas, specify C	of Hispenic Origin uben, Maxican, P lo <i>Specify</i> :	7 (Specify Yes or uarto Rican, etc.)		4. Race - Ar Black, W Specify: V	hita, atc.	ien,
72 h netu		Palaldinos	15. D (Specify on	acedant's Ed y highast gra	ducetion ade complated)		16a. Daced (Giva	lant's Usual Ockind of work do	cupation na during most of ired)	working	16b. Kind	d of Businas	ss/Industry	
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d 2 should be file th and Mental Hy 7 le marked oth traumatic event	1		19a. Intermant's Name/R		Type, Print)				et and Numbar o			Town, State	, Zip Code,)
1 and Heelth em 27		- h	John Wagner			less en			rive, Lu		-	2065		
permit. Pages 1 and Department of Heelth Important: If Item 27 any Injury or other tr			20a. Method of Dispositio 1 Burial 2 Crei 4 Donation 5 C	mation 3 [othar (Spacif	y)	cen	atary, cren lar Hi		tery Mar		1999 St		nd, Ma	aryland
Departiment Departiment any in	once.		21. Signeture of Funeral	Sarvice Licer).see				dress of Facility I a Ferry					
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/Medic Examin	al		Immadiata Causa (Final diseasa or condition rasulting in daath)		a ACUTE	MYO(JFARCT	TION			31	AYS
D #	i de			_					DIOVASC	WAR T	SEAS	SE	YE	ARS
law requires that the death certificate be executed as been signed by the attending physician end 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) I act												
ath certificete be exattending physician for use es the burial	n/Medical		resulting in daath) Last	l	d	Due to (or a	s a consequ	uenca ory:						
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es that igned by be deta	4									_ 1	☐ Yes 2 🚾	No 3□	Probably	4 Unknown
sician: The law requires the certificate has been signed irector, page 2 should be controlled.	Completed										as en eutops erformed?	y 241	available	on of causa
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or Attending I efter death. Director: After I in by the fune	cation		2 Accidant	Panding invastigation		Year)	Injury	28c. ir V M 1	ork?` □Yas 2□No	200. 2000.	, o 11011 injury	00001100		
al or Attend s efter death al Director: /	Certification:		3 ☐ Suiclde 6 ☐ 4 ☐ Homlcida	Could not be datarminad	28a. Place of Inju- building, etc	ury - At home: (Specify)	a, farm, stre	eat, factory, office	ee -		n (Street and Town, Stata)	Number or	Rural Rout	e Number,
To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the	edicai (29a. Cartifiar 1⊠ C (Check only one) 2 M	ertifying Ph	ysician: To the best of niner: On the basis of and manner sta	axamination	edga, daath n and/or inv	occurred at the astigation, in m	at the tima, data and place, and dua to tha causa(s) and mannar as stated. , in my opinion, daath occurred at tha tima, data and place, and dua to tha ca					ausa(s)
To the within 2 To the comple	ž		29b. Signature end titla of	certifiar				29c. Lice	nsa numbar		29d. Date	signed (Mo	onth, Day, Y	'ear)
			1/10			>0M		D-18	3545		MARC	H 22	2, 19	99
2		3	30. Name and address of DR. PHILIP W	person who	complated ceusa of de	aath (Itam 2:			RE #20	7 WALT				
Regi	State strar		31. Deta tilad (Month, Day	AR 2 3	1999 Nagistra	r's Signetur	а	G. 1	200 Kg					



State of Maryland	/ Department of Health and M	lental Hygi	ene 99	10597
	Certificate of Death	Reg	J. No.	10001
Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month	Day Yeer	3. Time of Death
WILLIAM CLAYTON YOUNG		MARCH 22	,1999	4:55 A
. Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo	cation of Death	4c. County of Death	

Physician /Medical Exami

1. Decedent's Neme (First, Middle,

Funeral Director

Pages 1 and 2 should be filed within 72

Baltimore, Maryland 2121

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be assecuted within £4 hours after death.

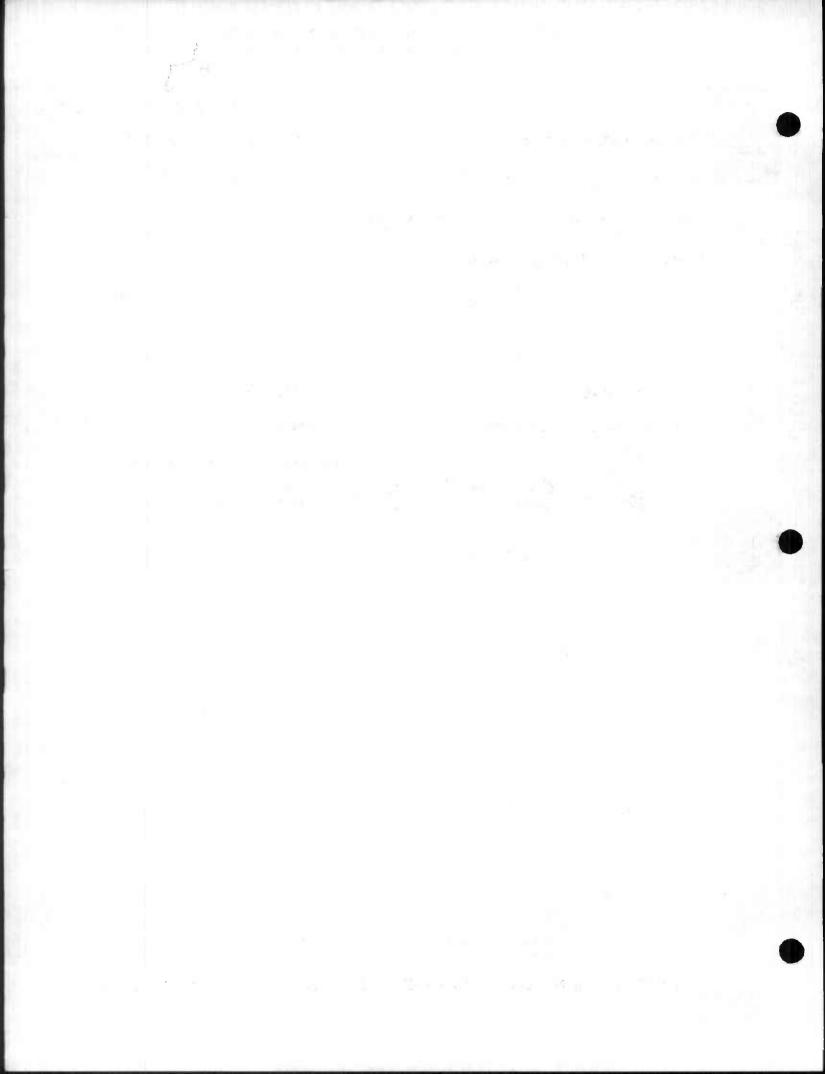
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

er	4e. Fecility Neme (I	f not institution	on, give	street end nu	ımber)					4b. City, To	own, or L	ocation of Dea	th 4	c. County	of Dea	th
	CIVISTA	MEDIC	AL	CENTER							PLAT	CA.	C	CHARI	ES	
	5. Sociel Security N 297–18–59		6. Se	ex MgM 2□F) (In yrs. 16 74	est birthday) Yrs.	If Unde Months	r 1 Year Deys	Hours Hours	Min.	8. Dete of B (Month, D	ley, Year		Co	thplece (State or Foreign
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	10e. Stete	10b. Count	У			10c. City	, Town or Lo	ocation								10d. Inside City Limits
Funeral Director	Maryland	Char1	es			Por	t Tob	acco								1 Yes 2 □ No
<u>ir</u> e	10e. Street end Nur	mber						10f. Zij	Code				10g. C	10g. Citizen of Whet Country?		
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ertilic	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deterr	not be nined	28e. Pleca build	a of Inju ling, etc	ry - At hon (Specify)	ne, farm, str	eet, fector	y, offica			28f. Location City or To			per or R	urel Route Number,
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State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0598 Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month iffona Alatzas 1999 14:02 March 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) N/A Johns Hopkins Bayview Med. Ctr. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 6. Sex Birthplece (State or Foreign Country) 1₩ 2□ F 222-05-5380 Feb. 1, 1912 Turke y Usual Residence of Daceden 10d. Inside City Limits 10s. State 10b. County 10c. City. Town or Location 1♥ Yes 2 No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 825 S. Grundy Street 13. Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Never Married 2 X Married 1 Yes 20000 If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner Restaurant 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Evangeline Terzis George Alatzas 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 825 S. Grundy St., Balto., Md. 21224 Margaret Alatzas / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 20a. Method of Disposition Qurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-2-99 Balto., Md. Demetrios Greek 22. Name end Address of Fecility 21. Signature of Funeral Repride Licensee Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 23a Party Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such es cardiac or respiretory at labor, or respiretory at labor, or respiretory at labor, or respiretory at labor. Approximate Interval Batween Onsat end Death Pneumonia Immediata Causa (Final Aspiration disease or condition resulting in death) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in deeth) Lest Due to (or as e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy 2 No 1 TYes 1 □Yes 2 □ No 25. Was case referred to medical 26. Plece of Daath (Chack only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Naturel 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide

the death certificate be execu Division of Vital Records, P.O. Box 68760. or Attending Physician:

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Physician

/Medical

Examiner

Funeral

Director

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altimore, Maryland 21215-0020

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29b. Signeture end title of certifier

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State Registrar

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29c. License number Res -000

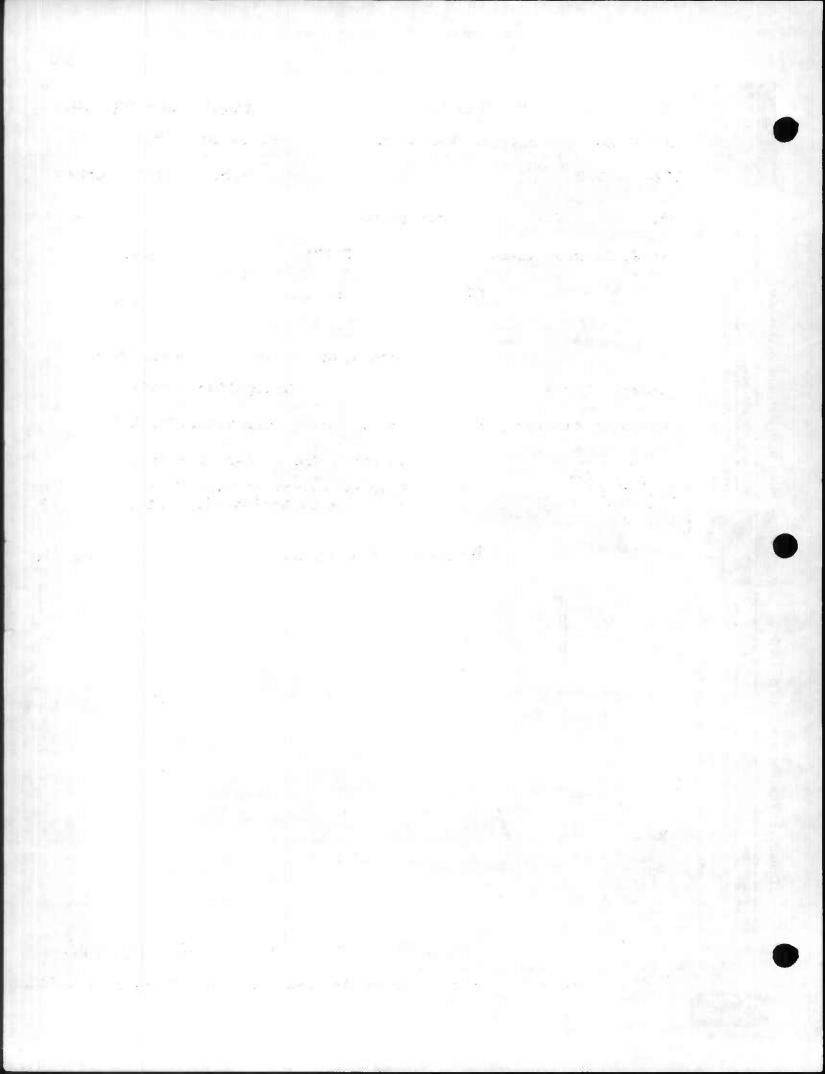
Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

| Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) March 30,1990

30. Name end eddress of person who complated cause of death (Itam 23a) (Type, Print)

Johns Hopkins Bayview Med. Ctr. Eastern Ave., 21224

32 Ragistrer's Signature -2/4



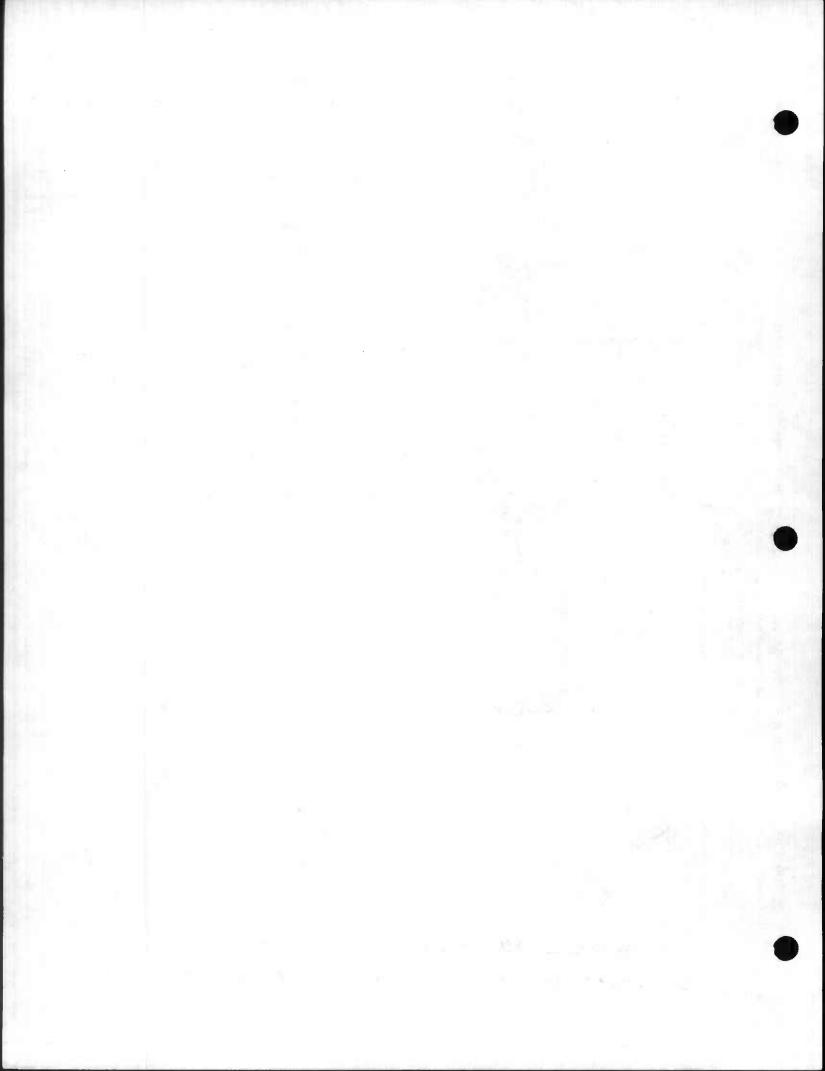
State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 **Physician** APRIL 1, DOUGLAS RALPH ALBRIGHT 5:45 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KNOLLWOOD NURSING HOME MILLERSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Months 123 M 2□ F 46 Yrs. Director 217-62-8815 MAY 29, 1952 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location tOd. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 179 FUNKE ROAD 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11 Maritel Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiena. ant: If Nem 27 le marked other than *natural; or fra 1 X Nevar Married 2 ☐ Married 1 ☐ Yes XX No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE P it Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greds completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A NOT EMPLOYEED NOT EMPLOYED 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERNEST ALBRIGHT THELMA MAE FILIATRAULT 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ERNEST R. ALBRIGHT (BROTHER) 119 BENFIELD ROAD, SEVERNA PARK, MARYLAND 21146 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stata Date permit. Pages 'Department of H important: If Ne eny Injury or of pace. cemetery, cremetory or other plece) 1 Burial 2 □ Cremation 3 □ Ramoval from Stata GLEN HAVEN MEMORIAL PARK 4/5/99 4 Donation 5 ☐ Other (Specify) GLEN BURNIE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licensee 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 n or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Pneumona 2 Days Immediata Causa (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events rasulting in death) Last the burial-trar Due to (or es a consequence of): P.O. Box 68760, Dua to (or as a consequence of): USB as signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? eter datus 2 No 3 Probably 4 Unknown Records, 2 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? this certificate 1 ☐ Yas 2 ☐ No Division of Vital after death.

Director: After this certifica director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To in by the funeral 27. Manner of Deeth 1 Denaturel 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide completely filled • Funerel Hospital Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29a. Cartifiar (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 2 D21684 4-2-1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHIE HWY, PASADENA, MO 21122 C-V. CYRIAC. M.D 8109 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** March 30, Mary Elizabeth Albertson 1:00PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 324 Dunkirk Road Baltimore Baltimore If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) April 10, 1920 Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 10 M 200 F Months 220-03-5800 Director Maryland Usual Rasidence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2VYNo Director Maryland Baltimore Baltimore the 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 324 Dunkirk Road 21212 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hyglene. Introducer: if item 27 is marked other than "natural, or item any injury or other traumatic avent, the Medical Experimental pages." Black, Whita, atc. 1 Yas 2 No 1 Nevar Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: by XX Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Hame 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Charles A. Tubman Ethel Dunnock 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Charles O. Albertson Son 208 Coldbrook Road Timonium, Maryland 21093 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1XXBurial 2 Cremation 3 Removal from State Dulaney Valley MEmorial Gardens 4/5/99 Lutherville, Maryland 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. thing of Funaral Sarvice Lic 6500 York Road Baltimore, Maryland 21212 23a. Part1. Entar tha disaasa, or dompli shock, or haart tailura. List only or ons that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory arrast, on aach line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physicien end the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobasco use contribute to the cause of death? the 3 1 Yes 2 No 3 Probably 4 Unknown signed l Records, þ 24b. Were autopsy tindings svailable prior to Completed 24a. Was an autopsy performed? peen Os teoporosus complation of cause of death? perparathy road is rossible 1 Yas 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was casa ratarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Manne of Death 28a. Data of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Tas 2 No 2 Accident 6 ☐ Could not be 3 Sulcida 28t. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to the cause(s) and menner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifie 29c. Licensa number 29d. Date signed (Month, Day, Year) 4212

State Registrar **DHMH 16 Rev 6/95**

31. Data tiled (Month, Day, Year) 32. Registrar's Signatura

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

William McConnell MD 500 West University Parkway Baltimore, Maryland 21218

March 31, 1999

Name Allechong or in

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 29, 1999 Richard P. March 5:20 AM Annis /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 9646 Dundawan Road Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year)
Dec. 2, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F 002-12-7828 Yrs. New Hampshire Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9646 Dundawan Road 21236 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW 77 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Wildowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decadant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) College (1-4or 5+) Construction Construction Worker 12th Grade 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine. Runnals Vern Annis 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 9646 Dundawan Road, Baltimore, MD 21236 Mrs. Virginia Annis (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Chother (Specify) Entombment Gardens of Faith Maus. 4/1/99 Baltimore. Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD May 1 21236 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each line. Approximate Interval Between Onsat and Death (Bronchogenic) Immediata Causa (Final < 6 months disaase or condition rasulting in death) Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medicai Due to (or es a consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yas 2 Ø No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manger of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to tha causa(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year)

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filed within 72 hours efter. Hygiene. Wher than "natural", or Rei

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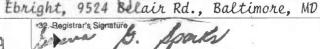
Baltimore, Maryland 21215-0020

Registrar

31. Date filed (Month, Day, Year)

Dr. Bradford L.

29b. Signature and title of cartille



30. Name and address of person who completed cause of death (Item 234) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Physicia /Medica Examine Funeral Director permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Exercises must be notified as Samuel Bates

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29d. Data signed (Month, Dey, Year)

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	25. Was case refe	rred to medica							26. Plac	e of Deet	h (Check only	one)			
5	examiner?	No	Hospitei:	Inpatient	2 ER/0	utpetien	t 3 DO	A Oth	oer:	-		sidence 6 🗆 O	ther (Spec	ify)	
	27. Manner of Deal	th	28a. De	te of Injury onth, Dey Y		Time of		8c. Injui				how injury occu			
	1 Netural 2 Accident	5 Pendir investi		ontn, Dey Y	ear)	Injury	М		Yes 2	No					
	3 Suicide	6 Could	not ba	ce of Injury	- At home, t	arm, str	eet, fectory	, office			28f. Location	(Street and Nun	nber or Rui	ral Route	Number,
5	4 Homicide	00.0111	bui	Iding, etc. (Specify)						City or To	own, Stete)			
2	29e. Certifier	1 Certifyin	g Phyeician: To t	he best of n	ny knowledo	e, death	occurred	et the tir	me, date er	nd plece	end due to the	e ceuse(s) end n	nanner as	stated.	
2	(Check only one)	2 Medical	Examiner: On the	basis of ex	aminetion a	nd/or inv	astigetion,	in my o	pinion, dea	ath occurr	ed et the time	, dete end plece	, and due	to the cau	ise(s)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

APR 2 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

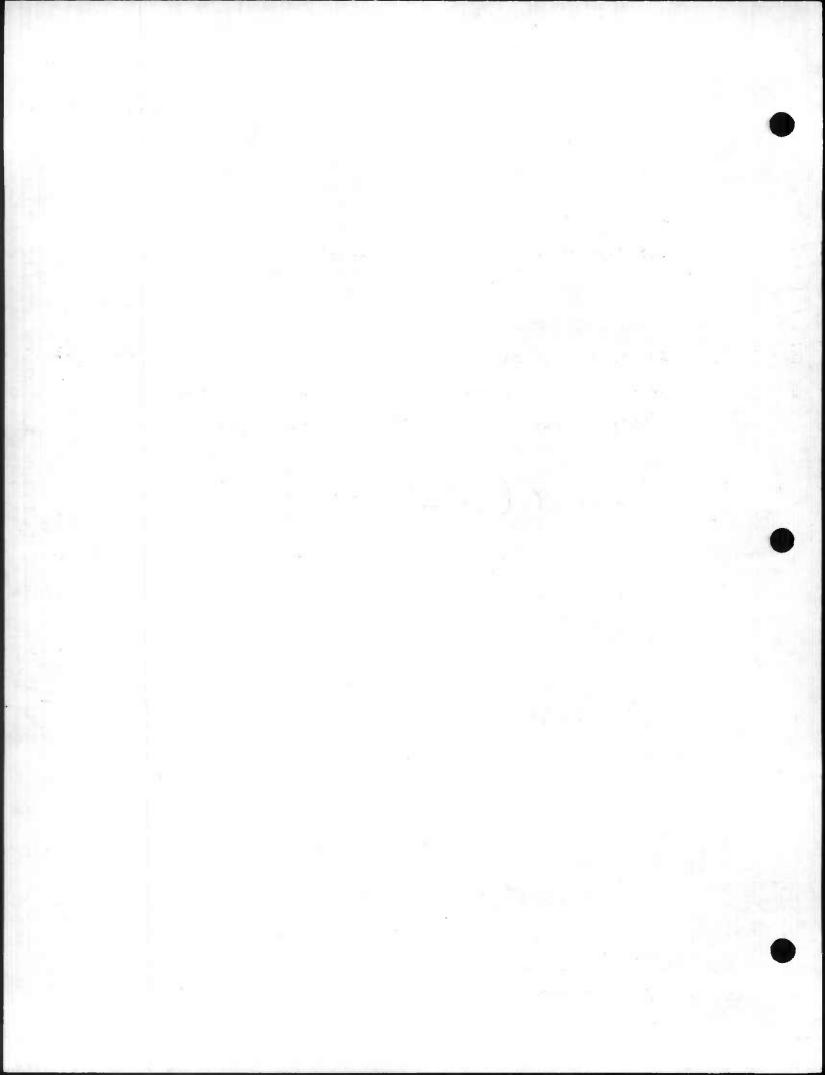
29b. Signature and title of certific

Dr. Daniel Shinners
31. Date filed (Month, Dey, Year)

Square Drive Battimore, mD 9000 Frankl 32. Registrar's Signature

ORIGINAL

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 607 BUMGARNER 30 99 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) BUTMORE (MARYUMO) MEDICAL Bromope Conner UMNERSHY OF If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. 1 M 2□ F 7. Age (In yrs. last birthday) Months Yrs. 73 245-14-2574 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2□No Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 U.S.A 10320 Congressional Ct. 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1943 IVYes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Swimming Pool Construction **Business Owner** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maude Stillwell Oscar Bumgarner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 10320 Congressional Ct. Ellicott City, Maryland 21042 Mr. Bradley Bumgarner Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 04/06/99 Garrison Forest, Maryland Maryland Veterans Cemetery 22. Name and Address of Facility mo0535 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 231 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Death immediate Ceuse (Final disease or condition resulting in deeth) SURFINE 16 HRR Due to (or as a consequence of): 16 HRS eaguro pathy Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) TROIAC reserv Due to (or as a consequence of) YRS Monosis Moren e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Herony 24b. Were autopsy findings available prior to 24a. Was an autopsy Mouns completion of ceuse of death? the becoming 200 No Kerenc Somosis 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

physician a Division of Vital Records, P.O. Box 68760, 8 980 signed by d after dest ŏ To the Hospital

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

r than "netural", or items 23s or the Medical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after death valopartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23 any injury or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic event, the house is to act or other traumstic events.

Physician

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Examiner

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2

Certification:

Medical

4 Homicide

altimore, Maryland 21215-0020

with the Maryland r 28a-f show

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier 190

WASE, M.D

APR 02 1999

29c. License number

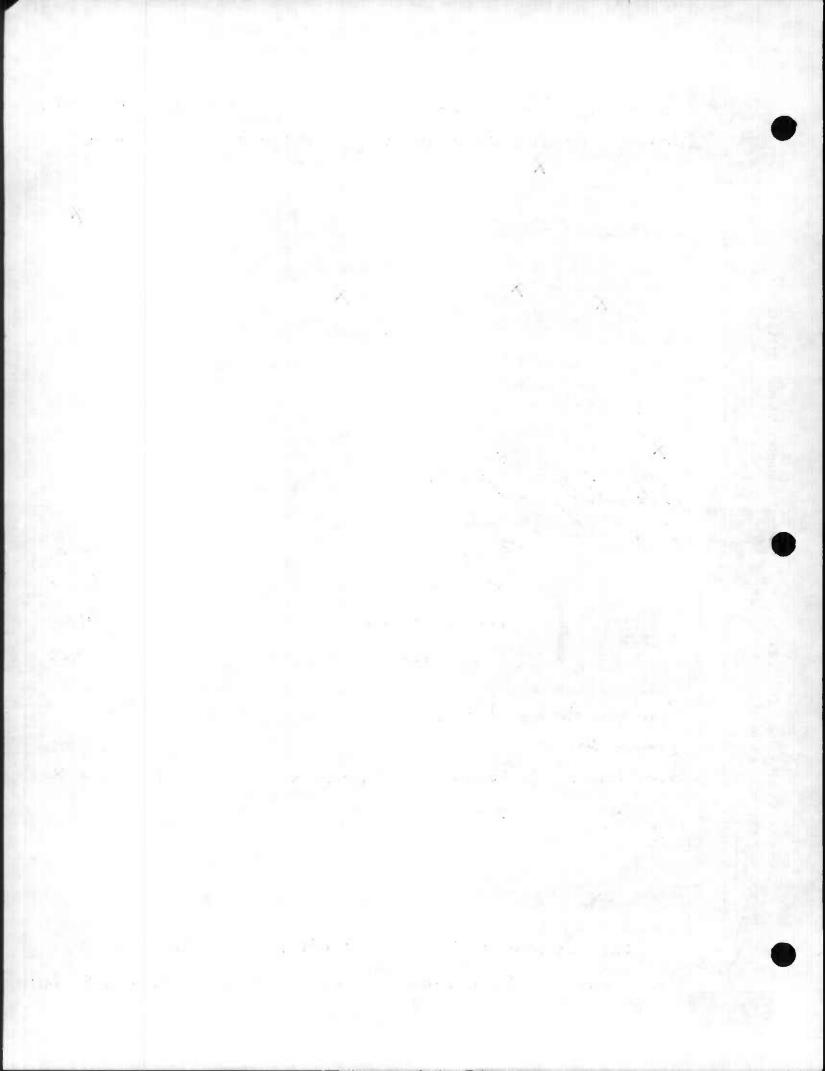
29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

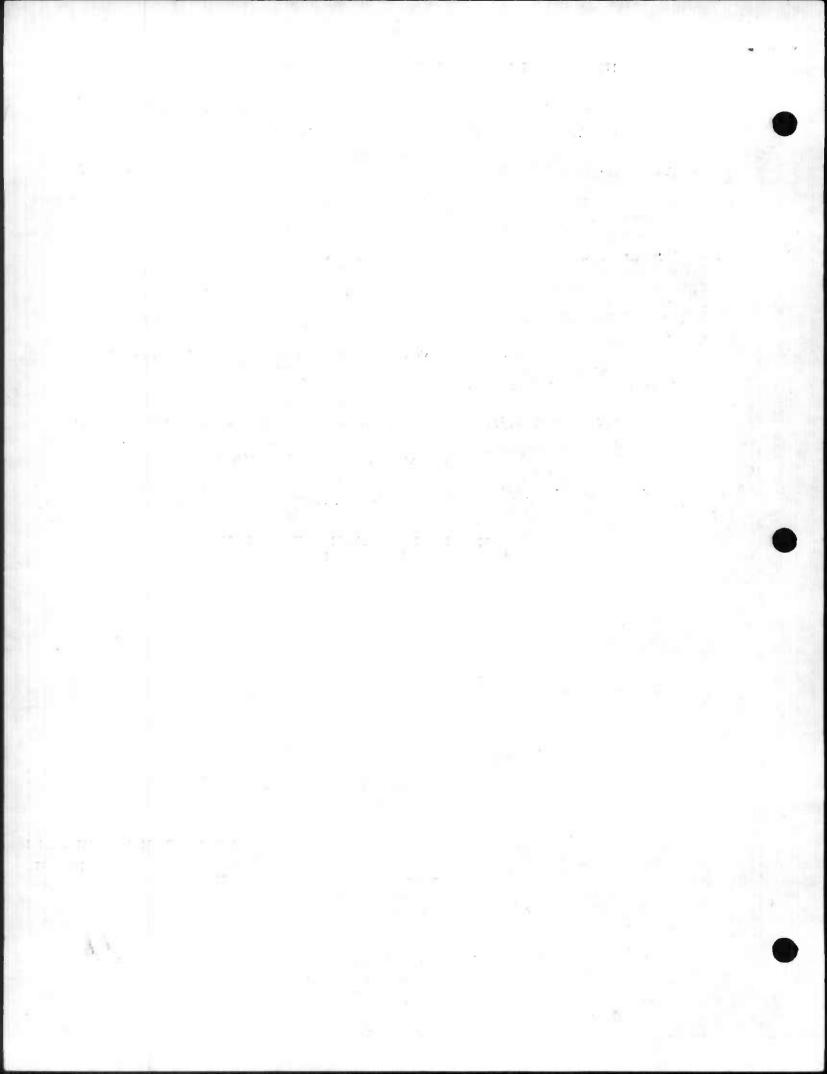
Musicing of Manyumo Mosium Conon 22 S. Grunne St. Bonomore, MO 21201

State Registrar



		Decedent's Neme (First, Middle, Last	PART I, 27, 28A-F	Certificate of	Douth	2. Dete of Dea Month	eg. No	Year	3. Time of Death		
	Physician /Medical	George Albert Wy		Sr.	4h City Tourn	MARCH or Location of Death	30, 19	999	10:22 AM		
	Examiner	4s Facility Name (If not institution, give UNION MEMORIAL)			BALTI		4c. County	or Death			
	Funeral Director	227-38-9645	7. Age (In yrs. la	yrs. If Under 1 Your Months Da		lin. 8. Dete of Birth (Month, Dey NOV . 28,	1933	9. Birthplac Country Virgi	e (State or Foreign nia		
	deeth with the Maryland ma 23a or 23e-f ahow man be notified at maral Director	Usual Residence of Decedent 10a. State 10b. County		Town or Location					Inside City Limits		
	eth with the Maryler 23e or 23e-f show matte mounted at	Maryland Baltimor	e Ess	S e X	le	1	0g. Citizen of \				
	Male of the control o			212				S.A.			
	r heme 23 direc must	11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	. 13. Was Decedent	of Hispanic Origin? Cuban, Mexican, Po	(Specify Yas or No- uerto Rican, etc.)		ce - American ck, Whita, etc.			
020	, or >	3 ☐ Widowed 4 🎇 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔯			Specify				
21215-0020	c 1 = 4	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usuel Oc (Give kind of work de life. DO NOT use re	one during most of	working	16b. Kind of B	usiness/Indus	itry		
	Hygiene. ther than		n/a	House Paint		Painting Contractor					
Maryland	a 1 and 2 should be filled within Health and Mental Hygiene. Item 27 is marked other than other traumatic avent, the To Be Comp	17. Father's Neme (First, Middle, Last) George Woodward	Blueford		Ruth	: Name (First, Middle, Maiden Surname) Ellis					
Man	4 e = =	19a. Informant's Neme/Relationship (7		19b. Meiling Address (St							
-	Health Item 27 other tr	George A.W. Blue	20b. Pla	8 Waldron A	1	1	20c. Location				
m 0	0 = 5	1 Burial 2 Coremation 3 4 Donation 5 Other (Specify	Hemovel from State	metery, cremetory or other imore/Washir		m.APR.5 I	aurel,	Maryla	and		
Baltimore,	Semit. Pa Departmen mportant: any injury anse.	21. Signature of Funerall Service Licen				neral Dir	ectors,	Inc.			
_		23a Port 1. Enlar the disease, or component, or heart feilure. List only	(Mooseou)			d. Randall			and 21133		
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	MULTIPLE INJ	OURIES COMPLICAT CARDIOVASCULAR as a consequence of):	ING ATHERS			O	itervel Between Inset and Deeth		
0,	be executed ician end puriel-transit		cause. Enter Underlying								
	et the death certificate be extra the attending physician etached for use as the buried by a state of the buried buried by a state of the buried buried by a state of the buried bu	annulting in doubt I age									
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0.	gned by the de detached be detached by Physic					1 D Y	es 2 No	3 Probab	bly 42 Unknown		
Records,	been should					24a. Wes e perfor	en autopsy med?	evaila	eutopsy findings able prior to eletion of cause ath?		
Œ	• - 9 E					1 DXY	es 2 No	1,27	res 2□ No		
	certificate inector, pa	25. Wes case referred to medical examiner?	11			Deeth (Check only or	10)				
of	F S D F	XXTes 2□ No	Hospitat: 1 ☐ Inpatient XX E			g Home 5 Resid					
on	Attending ir deeth. ector: After by the funa.	1 ☐ Naturat 5 ☐ Pending 2 ☒ Accident investigation	28a. Date of Injury (Month, Day Year) 3-30-99		njuryat Work? 1 ∐ Yes 2 🖾 No				ECT COLLISIO		
Ó	hal or Attending P na after deeth. al Director: After ed in by the funara Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)		28f. Location (S City or Tow BALTIMOR		ber or Rural R	SISSON ST,			
	Verthe Hospital or A within 24 hours after To the Funeral Direct completely filled in b. Medical Certif		reician: To the best of my knowl iner: On the basis of axamination			ace, end due to the c	ause(s) end m				
	within 2 To the comple		and manner stated.		ense number	2	9d. Date signe MARCH				
		30, Name and eddress of person who o	A V CACO	ZJ,MP	• C • F1 • E		PIARCE	ı JL,	1999		
		Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201									
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu								

ORIGINAL



Please Type or Print in Biack Indelibie ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3:30PM John A. Bryant, Jr. MARCH 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HOSPITAL ANNE ARUNDEL ARUNDEL DRTH Glen If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1∏M 2□F 220-09-9916 78 27, 1921 Feb. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 108 New Jersey Ave. N.W. 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1942 14. Race - American Indian, 11 Marital Status Black White etc 1X Yes 2 □ No If Yes, Give 1 Never Merried 2 XMerried 1945 White 1 ☐ Yes 2K No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) Overhead Foreman Gas & Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) John A. Bryant, Sr. Della E. Sears 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Katherine J. Bryant/Wife 108 New Jersey Ave. N.W. GLen Burnie, MD 21061 20e. Mathod of Disposition 20b. Pleca of Disposition (Nama of cemetery, cremetory or other ptece) Mar. 30 20c. Location - City or Town, State to Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Crownsville MD. VET. CEM. 4 ☐ Donation 5 ☐ Other (Specify) 1999 Crownsville, MD 21. Signeture of Euneral Service Licensee 22.Neme and Address of Fecility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23e. Pert 1. Enter the disease, or complications their caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one causa on aech line. Immediate Ceuse (Final diseese or condition resulting in deeth) Dreumon Due to (or es e consequence of): sinztim Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Lasi Due to (or es a consequence of): rophange of Ole Due 10 (of as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dapatieni 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined

Examiner sician and bunal-transit physician s the burial Box 68760. nse signed by the a P.O. Records, Division of Vital Aftar or Attending 24 hours after death.

Funeral Director: A

Hospital

Physician/Medical ò Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

ma 23a or 28a-f show

Herra:

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filed within 72 hours after

Maryland

Baltimore.

Hygiena.

Pagas 1 and 2 should be fill ment of Health and Mental Hisant: If Item 27 is marked oth

Depertment

Important: If it any injury or o

Physician /Medical

Examiner

Director

Funeral

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Be Completed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

edical

completely

within 2 the sta

DHMH 16 Rev 6/95

31. Dete fited (Month, Dey, Year) State Registrar 2 1999

29b. Signeture end title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrer's Signeture

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To tha best of my knowledge, daath occurred at the time, data end place, and due to tha cause(s) and manner as stated.

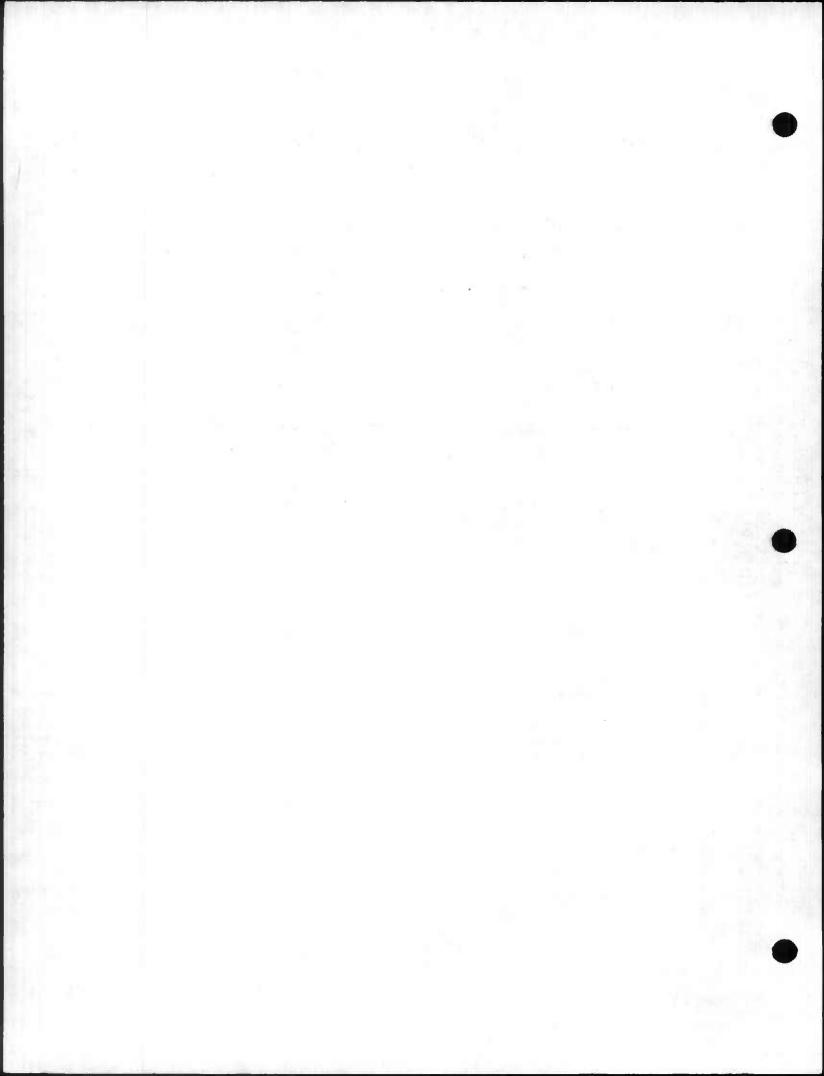
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) and menner steled.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

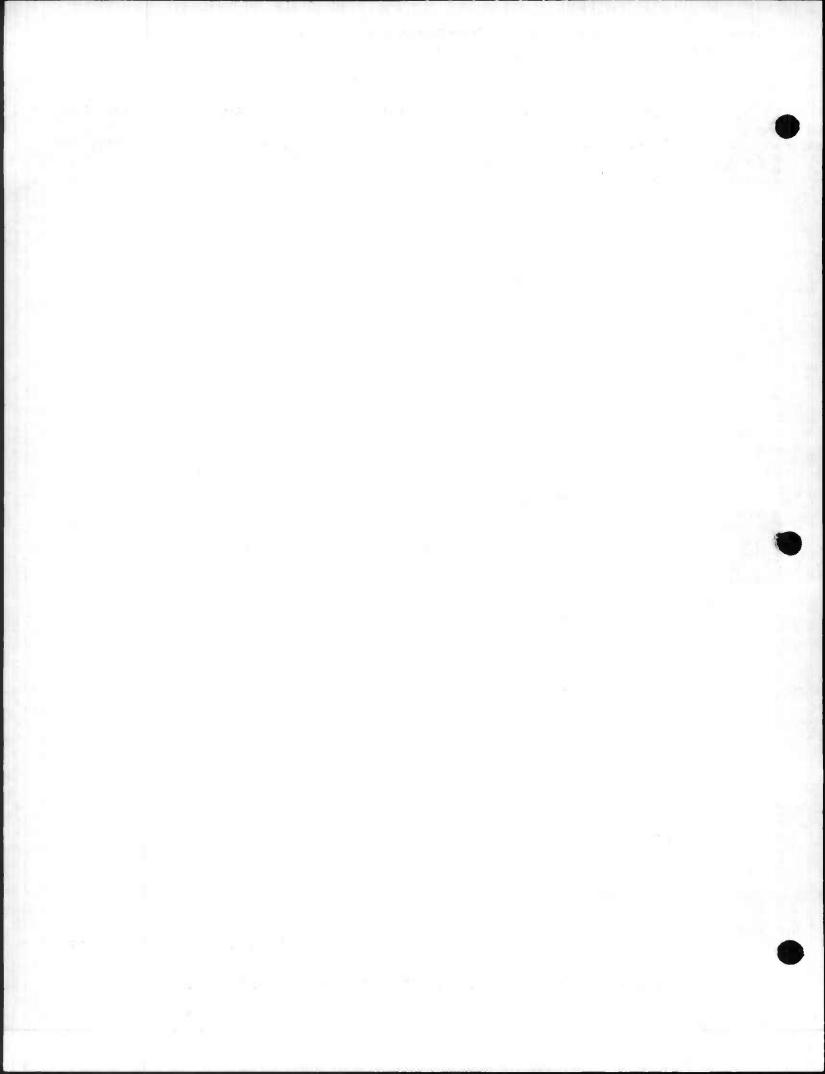
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 2. Dete of Deeth 1. Decedant's Neme (First, Middle, Last) 3. Time of Deeth **Physician** Month Year **JEAN** BURKE MARCH 26 1999 9:00 PM /Medical A. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 608 141ST STREET OCEAN CITY
If Under 24 Hrs. 8, [WORCESTER If Under 1 Year 8. Dete of Birth (Month, Day, Year) FEB. 20, 1928 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthpleca (Stete or Foreign **Funeral** Deys Hours 1□ M 2XF WEST VIRGINIA 71 Yrs. Director 233-38-9207 Usuel Residence of Dacedeni Peges 1 end 2 should be filed within 72 hours aftar death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, it a Medical Examinet must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MARYLAND WORCESTER OCEAN CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 608 141ST STREET 21842 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No by Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Collega (1-4or 5+) BEAUTICIAN BEAUTY SHOP 12 Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be LUTHER BALDWIN ADDIE ETHEL COLLIE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Straet end Number or Rural Route Number, City or Town, Stete, Zip Code) PHILIP J. BURKE / HUSBAND 608 141ST ST., OCEAN CITY, MARYLAND 21842 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Mathod of Disposition 20c. Location - City or Town, Stete MARCH Department of Important: If It any Injury or o 1 Bugial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GLEN HAVEN MEM. PK. 29, 1999 GLEN BURNIE, MARYLAND of Funeral Service/Licensee 22. Neme end Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feitura. List only one cause on aech line. **Physician** Immediate Cause (Finet disease or condition rasulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner The lew requires that the death certificete be executed the buriel-transit pue Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in deeth) Last Due to (or es a consequence of) Box 68760. physician Physician/Medical Due to (or es e consequence of) 60 signed by the ettanding the detached for use Pert il. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. P.0. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara eutopsy findings eveilable prior to completion of cause of daath? page 2 should Completed 24e. Wes en eutopsy certificata has 1 ☐ Yes 2 DAK 1 ☐ Yes 2 ☐ No of Vital al or Attending Physician: T s eftar deeth. il Director: After this certifical funerel director. 25. Wes case raferred to medical axeminer? Be 26. Piece of Deeth (Check only one) 1 Yas 2 Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel 2 Accident 1 TYes 2 No in by the 6 ☐ Couid not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a. Certifian Tacettifying Physicien: To the best of my knowledge, deeth occurred at the tima, data and piece, and due to the cause(s) and mannar as statad. Medical (Check only one) 2 Medical Exeminer: On the bests of exeminetion and/or investigetion, In my opinion, death occurred et the time, dete end placa, end due to the ceuse(s) end menner steted. 29b. Signeture end title of cartifier 29d. Date signed (Month, Dey, Yeer) 29-99 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) STEPHEN F. WATERS, MD 10TH STREET, OCEAN CITY, MARYLAND 21842 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month RUTLER 2-55 Am MARIE MARCH 1999 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 5000 HOSPITAL SAMARITAN BALTIMORE BOYTIMORE CIT 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthpleca (Steta or Foreign Country) 1 □ M 2 🗓 F Months Deys Hours Yrs 215-56-6272 108 1-5-1891 unknown 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD. BALTIMORE 10e. Street end Number 10f. Zlp Coda 10g. Citizen of What Country? 21206 6116 BELAIR RD. S. A. 14. Reca - American Indian, Black, White, etc. 12. Wes Decadent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 Ø No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced BLACK 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) unknown RETIRED 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Surname) unknown unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) OVERLEA, MARINER 20b. Place of Disposition (Name of cametery, cremetory or other place) BALTIMORE MD. 21206 20c. Location 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) MT. ZION CEMETERY 4-7-99 BALTIMORE MD 21 Signeture of Funeral Service Licenses 22. Nema and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD. 21217 23a. Pert1. Enter the diseasa, or complications thet caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onsat and Deeth Immediate Ceuse (Finel SEPSIS disease or condition resulting in deeth) OHEDAY Due to (or es e consequence of): PNEUMONIA Two WEETES Sequantially list conditions, if any, leeding to immediate causa. Enter Underlying Causa (Diseese or injury thet initieted events resulting in death) Lest Due to (or as a consequence of) Dua to (or es e consequance of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilabla prior to completion of causa of daeth? 24a. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death with i Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or is any injury or other traumatic event, the Medical Examinar must be no

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

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Examiner Physician/Medical by Completed Be ို

Medical

sician end buriel-trensit physician s the buriel signed by t this funerel To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th compietely filled in by the funeral Certification:

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25. Wes case refa	rrad to medical		26. Plece of Daath (Check only one)												
examiner?	No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Home 5 ☐ Residenca 6 ☐ Other (Specify)										
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	28c.	Injury et Work? 1 Yes 2 No	28d. Describe how Injury occurred									
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29b. Signeture and title of comil

29c. License number P12557 29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed causa of daath (Item 23e) (Type, Print)

DoDoo 5601 LOCA RAWN BLUD BALTIMORE MD 21239-2985

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 7:14 Am 1999 Willie /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner PinAi Hospital ot BAHimore BALTMORE
If Under 24 Hrs. 8. Dete of DARtimore If Under 1 Year 8. Dete of Birth
Timonth, Day, Ye 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 2/2-26-389 Usuei Residence of Decedent 1□ M 200 F Yrs 119 Director 10e. Stete 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director Maryland 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number apt. filed within 72 hours after death with 706 2n ST, 706

12. Wes Decedent Ever in U.S. Armed Forces? d 12 Rece - American Indien, Bieck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify. Negro Specify: by 3 Widowed 4 Divorced "naturel", Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) P lith and Mental Hygier 27 is marked other the treumatic event, In 17. Fether's Neme (First, Middle, Last) Mother's Name (First, Middle, Maiden Surneme) 9 agar reora permit. Pagas 1 end 2 should I Department of Health end Meni important: if item 27 is marked loore 19 19b. Mailing Address (Street end Number or Rural Royte Nymber, City or Town, Stete, 19a. Informant's Name/Reletionship (Type, Zip Code) Print) ernarc 4 Pomona
20b. Pleca of Disposition (Neme of 0 Baltimore, 20c. Location - City or Town, Stete 20a. Method of Disposition Date/ cemetery, premetory or other place) 20 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Libensee Joseph North 21216 Bal Approximete Interval Between Onset end Deeth er the claudse, or complications that caused the deeth. Do not enter the mode of dying, such as can heart failure. List only one couse on each line. **Physician** /Medical Immediate Ceuse (Finai Staph 10 coccus week disease or condition resulting in deeth) Examiner the the Ra Godeluesse of): A D ovidencia stuartic Examiner attending physician and for use as the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, iabetes W داء Physician/Medical Due to (or es e consequenca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en autopsy page 2 s Sale 1 Yes 25 No 1 Yes 2 NO certificate diseAS 0 or Attanding Physician: After this certification, 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 25 No 15thpafient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury ef Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Naturel 5 Pending in 24 hours efter deau...
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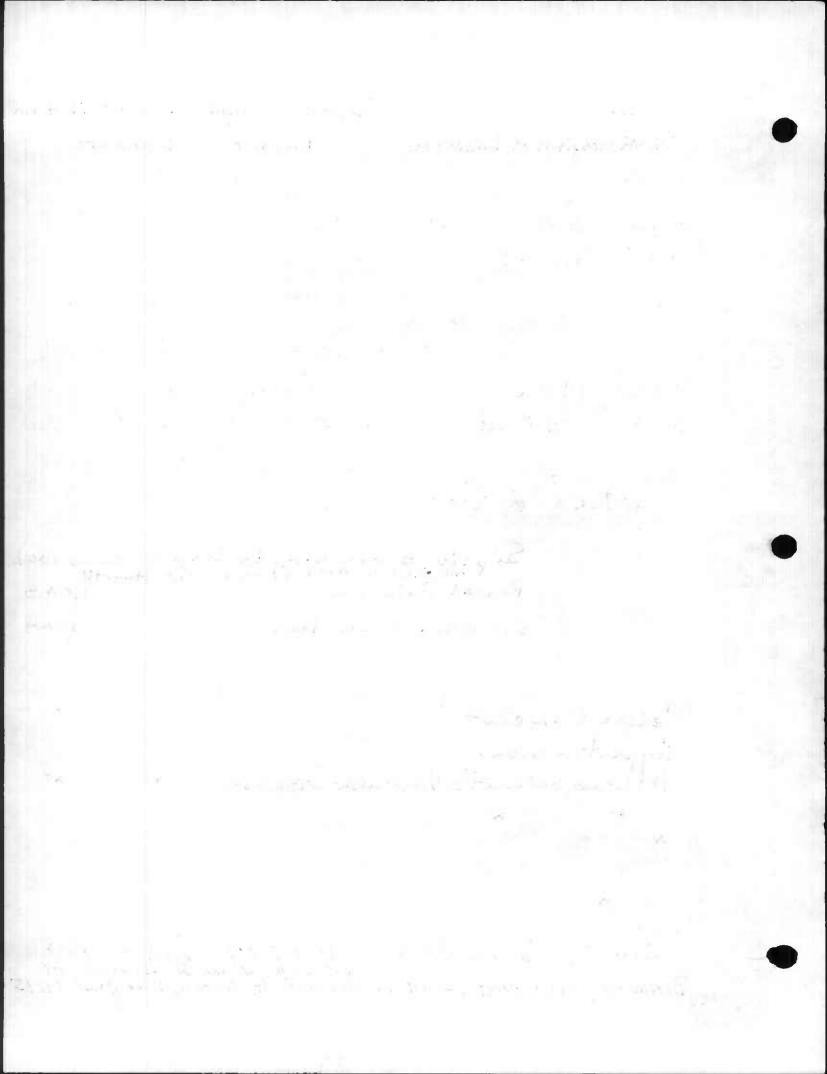
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. edical 29a. Certifier completaly (Check only one) within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signetyte end title of cartified Wast Dolueden
32. Registrer's Signature 30. Name and address of prison who completed cause of deeth (Item 23e) (Type, Print) Resident Plussicity, SiNAi HOSPITAL

DHMH 16 Rev 6/95

State Registrar Date filed (Month, Day, Year)

APR Q 2 1999

Areani, Brotmore,



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State of Maryland / Department of Health and Mental Hygiene 9 10609

		Decedent's Neme (First, Middle, La	st)	Certifica	ale oi	Dealli	2. Date of Deatl			e of Death
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/Medic		4e Facility Neme (If not institution, giv	e street and number)			4b. City, Town, or Le	ocation of Death	4c. County	of Death	
CAGITITA	-	VAMHCS Fort Howa	rd Division			Fort Ho	oward	Bal	timore	
Funeral Director		5. Social Security Number 6. S 217-07-0021 Usual Residenca of Decadent	7. Age (In yrs.		der 1 Year ns Days		8. Date of Birth (Month, Dey, May 27,	1913	9. Birthplace (Sta Country) Baltimor	
/land		10e. State 10b. County	10c. Cit	y, Town or Location					10d. Inside	e City Limits
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or 28)ire	10e. Street and Number	#417	10f.	Zip Code		10	og. Citizen of V	Vhat Country?	
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Baltimore, permit. Pages 1 er Department of Hear Important: if item; any injury or other once.		21. Signature of Funeral Service Licar			and Addr	ess of Facility Do	uslass	Fune	eral Sei	vice
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100		30. Name and address of person who Augustin Chvu, M		oint Road	Eov	+ Horman	MD 21052			/
	е	31. Dete filed (Month, Day, Year)	32. Registrar's Signa		FOL	- HOWALU,	ALUSZ			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month 40 **Physician** MABEL COWANS 025 1999 mak. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holly STREET BALHMUIE If Undar 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Hours 1□ M 22 F 36-9083 Director 10,1925 5 Cmolin Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 28a-f show 10 YES 2 No BALLINOVE Director 16,44,000 10f. Zip Code 10e. Street and Number 10g. Citizan of What Country? 'naturel', or items 23s or 21229 12. Was Decedent Ever in U,S. Armed Forças?

1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify Bla-clo à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hyglene. Electric C Elementary/Secondary (0-12) College (1-4or 5+) Operator MACHINE permit. Pages 1 and 2 should be filed will Department of Haelth and Mental Hyglen Important: If Item 27 is marked other the eny Injury or other treumatic event, the page. 12 UE ARS 17. Fathar's Mame (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be MOSES BESSIA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Lucy Burgess 1008 Mit. \$10/14 STREET BAltiture, Med 2/229 20c. Location - City or Town, Stata FRIERD 20b. Place of Disposition (Nama of cematary, crematory or other p 20a. Mathod of Disposition Data 3-29-99 Burial 2 Cramation 3 Ramoval from Stata Park Cinetry SUDON 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility CHATMIN 5240 REISTERS FOWN RUAM 23a. Part1. Enfer tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heert failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) MyoCarpiol INFARCTION Ihr. Examiner Dua to (or as a consequence of). Examiner pentensien attending physician and for use as the bunal-tran-Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Diseesa or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ASTMA ð 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performad? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminar? Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatiant Other: 4 Nursing Homa Rasidanca 6 Othar (Specify) 1 Yas 2 10 edical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how Injury occurred Hospital or Attending 5 Panding investigation 1 Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All complately filled in by the fu death. 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and placa, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to tha causa(s) and mennar stated. 29a. Cartifiar

State Registrar

(Check only one)

29b. Signature and titla of certifiar

31. Data filed (Month, Day, Year)

Cusma. Strops.

APR

30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print)

altimore. Maryland 21215-0020

Box 68760

P.O.

Records,

of Vital

Division

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4001 Leberry

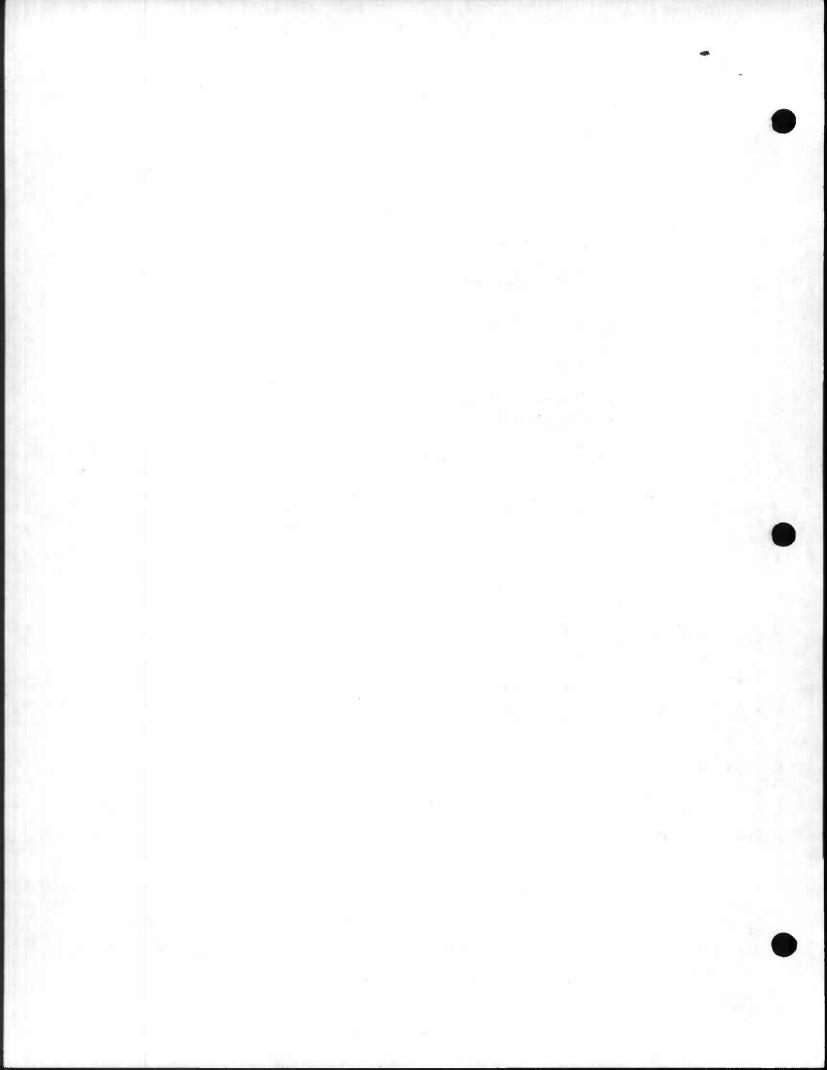
32. Registrar's Signature

29c. License number

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29d. Data signed (Month, Day, Year)

Ave Balts my



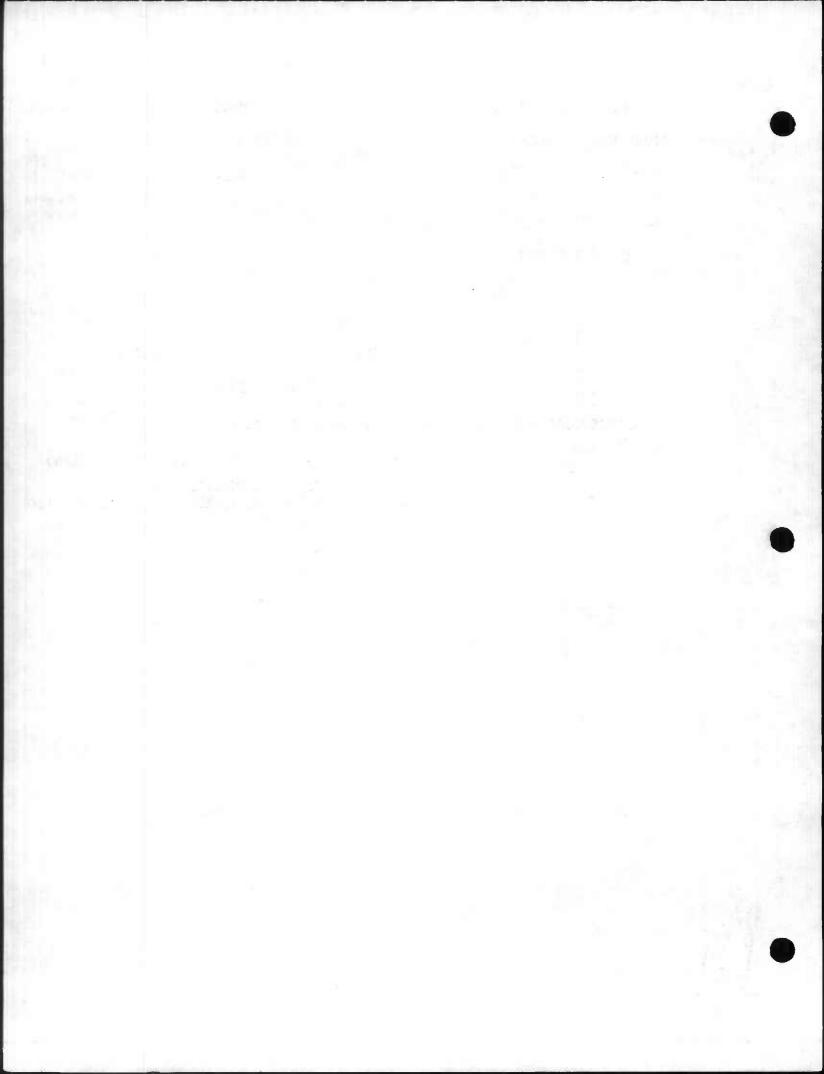
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** VIVIAN ANNA CZYZIA MARCH 28,1999 4:44 p.m. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) Aug. 2,1921 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days 1□M 2 1 F Hours Months Yrs 220-03-5642 Director MARYLAND Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at YXYes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or U.S.A. 3029 ELLIOTT STREET 21224 Funerai 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 200 to If Yas, Giva Yaer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck White etc 1 ☐ Never Merried 2 ☐ Merried natural, or Baltimore, Maryland 21215-0020 1 Yes 2000 Specify: Specify: by 3XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 DOMESTIC HOUSEWIFE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be life Department of Heelth and Mentel Hy Important: if Item 27 is marked oth any Injury or other traumatic event obce. Be JOHN MILKE RUBY LEONARD 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE LEWKIEWICZ/ DAUGHTER 2219 WILHELM AVENUE, BALTIMORE, MARYLAND 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 4/1/99 BALTIMORE, MARYLAND 21. Signature of Funeral Santa Licensee 22. Nama and Address of Fecility
LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediata Ceuse (Final Tachycardia Ventricular 10 minutes disease or condition resulting in deeth) Examiner Physician/Medical Examiner yocardiai Infarction 2 days attending physicien end for use es the burial-transit that the death certificeta be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury thel initieted events resulting in daeth) Last P.O. Box 68760, Coronary Dua to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Hypertension signed b Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed pege 2 20 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Euneral Director: After this certifica stely Titled in by the funerel director, I 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 I Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filted is 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end mannar steted. 29a. Cartifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Brannanto AU4176435B9829 and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Scatt Brannan MD Paca Street, Baltimore, MD 31. Date filed (Month, Dey, Year) 32 Registrer's Signature State

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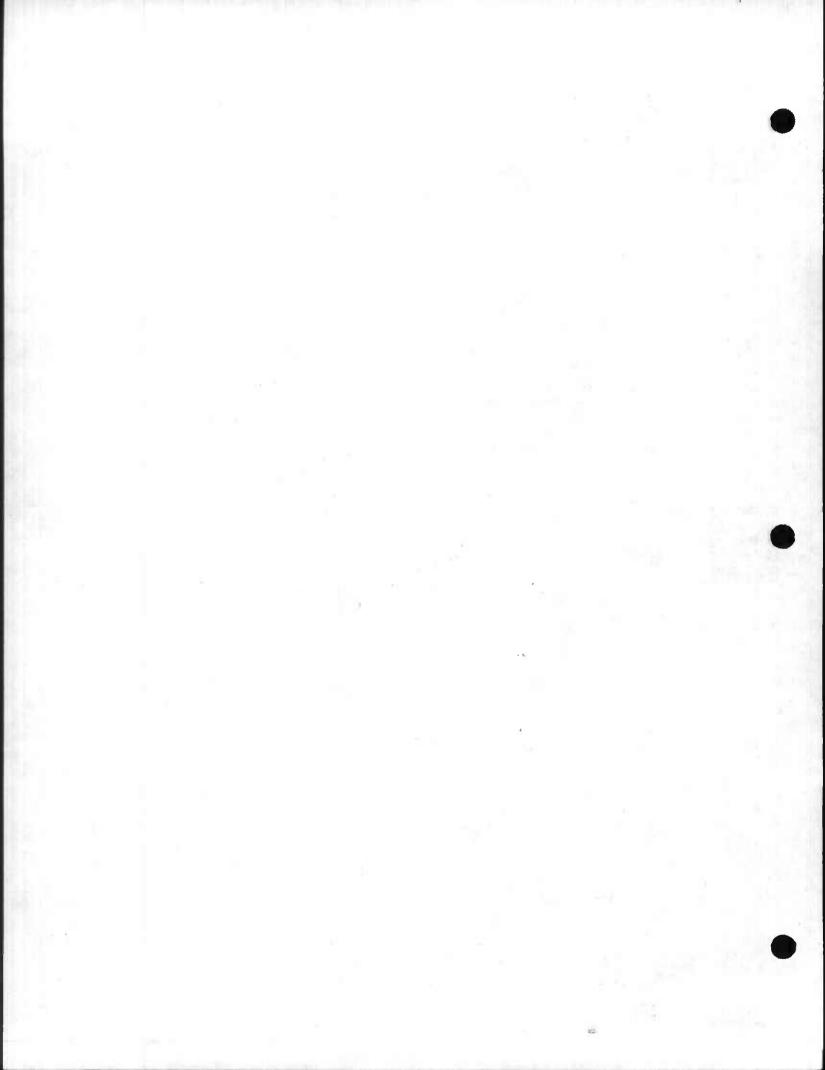
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	No Maria	cto	MD N/A		Balt	imore					1 Yes 2	NO
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	/Medical		mmediete Ceuse (Final lisease or condition							5 1		
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			JAY G SHAKE, M	I.D., JOHNS	HOPKIN	NS HOS	SPITAL,	BALTIMO	RE, MARY	LAND	21287	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month **Physician** FVELTN ARCH 30 2031 COPFIELD /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva straat and number) Examiner ERLY HOSPITAL BACTIMORE If Undar 24 Hrs. 8. Dete of Birth If Undar 1 Yeer 5. Sociei Security Number 7. Age (In yrs. lest birthday)
Yrs. 9. Birthplece (State or Foraign **Funeral** 218-62-730 1□M 2MF Months Days Director Usuel Rasidenca of Decedent with the Marylend 10e. Stete 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 XYes 2 □ No Director 10g. Citizen of Whet Country? ŏ items 23e rook Funeral permit. Peges 1 and 2 should be filed within 72 hours efter deeth Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23 14. Reca - American Indian, Bleck, White, etc. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 M No If Yes, Give Year or Detas: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) er 10 17. Fether's Neme (First, Middle, Last) Be 19b. Mailing Address (Street end Nun 20a. Method of Disposition 1 Burial 2 Cremetion 3 R 4 Donation 5 Other (Specify) 3 Removel from State any injury or oudon 22. Name end Address of Facility L. Russ Funeral W. North Ave. Balto. M 1d.21216 that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, to on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) ARCOIDOSIS 10 disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner MONIA buriel-tren Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or es e consequence of): pue Division of Vital Records, P.O. Box 68760, physicien that the death certificate be Physician/Medicai the Dua to (or as e consequanca of): 80 USB signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably ➤ Unknown 1 ☐ Yss 2 ☐ No Completed by 24b. Were autopsy findings available prior to 24a. Was en eutopsy peen completion of cause of deeth? page 2 No 1 □ Yes 2 □ No certificate 1 Yes or Attending Physician: funerel director, 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this Certification: 27. Manger of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending after deeth. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefa) 3 Suicida 28e. Pleca of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Sertifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) To the To the To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. License number MARCH 30, 1999 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) TIMORE ND COSTO 301 65 EP9-1 ST

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State

Registrar

31. Dete filed (Month, Dey, Yaar)

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02 1999

32. Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Deeth **Physician** 9:15 pm March dna /Medical 4e. Fecility Neme (If not institution, give street end nymber) 4b. City, Town, or Location of Deeth Examiner Agnes Baltimo If Under 24 Hrs. 8. Pit Baltimone tos Le 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) 12-5-/ **Funeral** 1 □ M 2 ▼ F 3 Months Deys Hours Yrs. Director 219-22-2773 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits the Medical Examiner must be notified at Director Ma WA Ba Himore 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or Holly Street 4.5 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Stetus 14. Race - American Indian. Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ò altimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify by 3 Widowed 4 □ Divorced Black "natural", Yeer or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry FOX Carrol Hygiene. onlary/Secondary (0-12) College (1-4or 5+) NA Domestic is marked other Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) end Mental Bray boy Whitherspoon 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2. Department of Health e Important: If item 27 is any injury or other tray once. Alberg Balto Joughter Lane Ma 2/220 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) rison tored 32. Name end Address of Fecility Harch, F. H. Was + 21. Signature of Funeral Service License Hvenue Baltoind 300 Warbash 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel with respirator disease or condition resulting in deeth) Examiner Physician/Medical Examiner Encophalopas the death certificate be executed physician end s the buriel-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence ot): P.O. Part II. Other eignificant conditione contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by th. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? page 2 should Be Completed 24e. Wes en eutopsy performed? this certificate 1 ☐ Yes 2 ☐ No of Vital the funerel director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 1 Yes 2 No Certification: To 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Injury death. 1 Yes 2 🗆 No within 24 hours efter deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner as steted. 2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Dey, Year) e of deeth (Item 23a) (Type, Print) 900 Baltimore, MD Caton

State Registrar

DHMH 16 Rev 6/95

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31. Dete filed Mon

32 Aegistrar's Signature

B WANT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Dey **Physician** 1999 GARY CORNISH MARCH 30 21:12 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdey) **Funeral** 10M 20F Days 218-60-83x Yrs. ary I an Director Usuel Residence of Decedent the Marylend 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 HTes 2 □ No Director mol 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1206 4880 LISIA Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Wes Decedent Ever in U,S. 11. Maritel Status Armed Forces?

1 Yes 2 1 Ves if Yes, Give Year or Detes: Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Heelth and Mental thygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Exemines. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ HO Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) entary/Secondary (0-12) College (1-4or 5+) Hous ing aintance 2 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Buello Murph 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8 DINISH ernes 20e. Method of Disposition 20b. Place of Disposition (Neme of A competery, cremetory or other place) Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility any in service 1213 Approximete Intervel Between Onset end Deeth he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest **Physician** Immediate Cause (Final diseese or condition resulting In deeth) /Medical ASYSTOLE 23 HOURS Examiner Due to (or es e consequence of): Physician/Medical Examiner INTERCRANIA HEMMORRHAGE 23 HOURS ettending physician and for use as the buriel-trensit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events Due to (or es e consequence of) Box 68760. Due to (or es e consequenca of): resulting in deeth) Lest ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 ☑ Unknown HYPERTENSION Records, þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen END STAGE RENAL DISEASE hes page director, page 1 ☐ Yes 2 No 1 Yes 2 GNo Division of Vital Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2☑ No 1X Inpatient 2 ER/Outpetient 3 DOA Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how Injury occurred Certification: or Attending 1 Naturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hours the Funeral Dire 29a. Certifier 🖾 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number RES 000 MARCH 30, 1999 18 hr

State Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year)

JOHNS

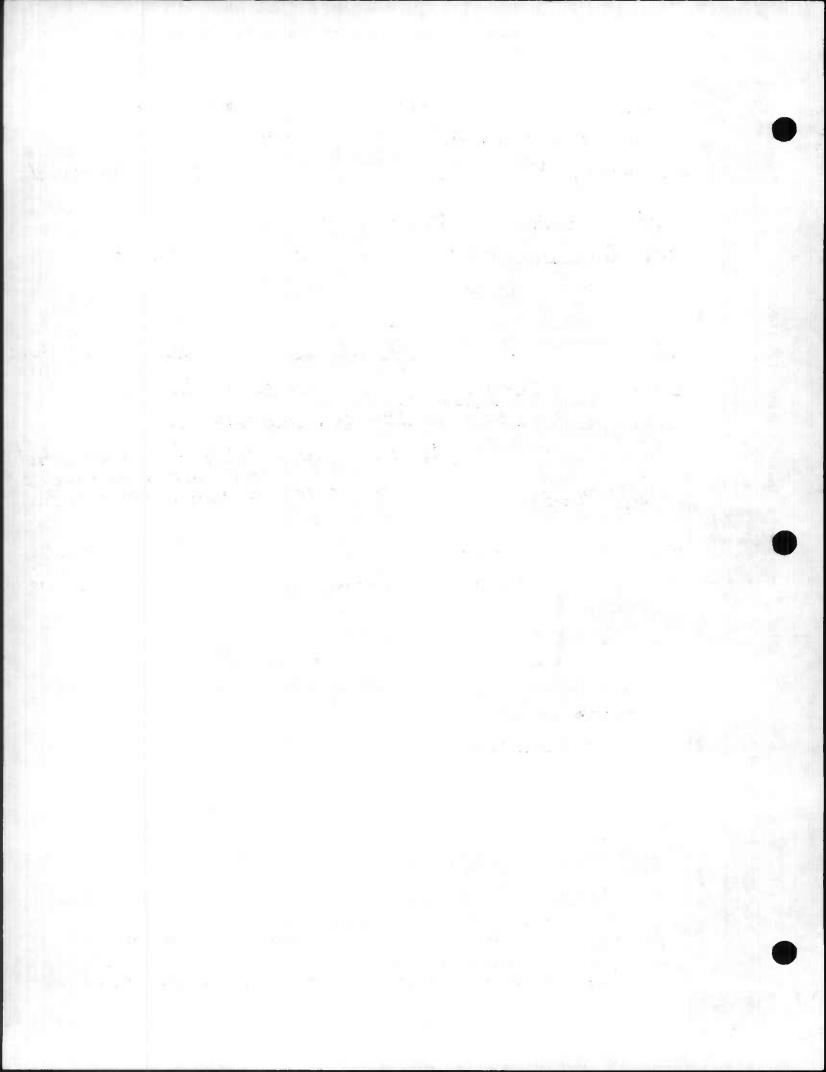
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)



600 NORTH WOLFE STREET

21287

JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Physician 6 MAR /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore If Under 24 Hrs. 8. Data of Birth er Sing al 8 9. Birthplace (State or Foreign Age (In yrs last birthday) Under 1 6. Sex **Funeral** Months Days 6,1922 Maryland 215-14-0382 Usual Rasidance of Decedant 1 M 2 F Director 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f eho altimore 1 as 2 No **Funeral Director** laryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21216 on 12. Was Decedent Evar in U,S. Armed Forces?

1 Vas 2 No If Yes, Giva Hems Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American todian, 11. Marital Status Black, Whita, atc. the Madical Examiner 1 Nevar Married 2 Married 21215-0020 9 1 Yes 2 No Specify: by African-American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent if them 27 is marked other than ury or other traumetic event, the Ma Elemantary/Secondary (0-12) College (1-4or 5+) 2 Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ames ora 19a. tntormant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) balto. Md. 21216 xton 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Mathod ot Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from Stata
Donation 5 Other (Specify) Department of Important: If any Injury or torest 22 Nama and Address of Facility
JOSEPH L. K
2222 W. No 21. Signature of Funaral Sarvice Licenses inera WiNorth 5a.1to. Md. 212/6 Ave. nter the dunese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rhear failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Finai disaasa or condition resulting in daath) Examiner Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part tl. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown lension Division of Vital Records. þ 24b. Wera autopsy findings available prior to completion of causa of death? Certification: To Be Completed 24a. Was an autopsy 1 Yes 2 UNo 1 Yes 2 10 25. Was casa referred to madical axaminar? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 2 27. Manne of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Panding invastigation 1 Yes 2 No 2 Accidant after death Director: 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral S 29a. Cartifiar 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certitian 29c. License number 1 ale ot person who completed sausa of death (Item 23a) (Type, Print) Belindere ane a ani 31. Data filed (Month, Day, Year) 2. Registrar's Signatury State APR 0 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 1999 03:20 AM Anna MARCH /Medical 4c. County of Deeth 4a Fecility Neme (If not institution, giva straet end numbar) 4b. City, Town, or Location of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE 8. Dete of Birth (Month, Dey, Yeer) Sept. 4, 1924 If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F Months Deys Hours Min. Yrs. 218-18-2265 74 Director Usuel Residence of Decedent the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo Baltimore Baldwin 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? d 2 should be filed within 72 hours efter death with in and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, The Medical Example event, The Medical Example or the market. 2918 Placid Drive 21013 United States Funeral 12. Wes Dacadant Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Status Black, Whita, atc. 1 ☐ Yes 2 🕱 X Vo If Yes, Give Yeer or Dates: 1 Navar Married 2 Married 1 ☐ Yes 2)XNo Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home 9 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middla, Last) Be Mary Vincent Difara: Dukka 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Health of Health Ellicott City, Maryland 21042 Mr. Raplh DaLesio/ Son 4312 Sweet Bell Court 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Peges 1 permit. Peges
Department of
Important: if it
any injury or o 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith 04/05/99 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Coster 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onsat and Daath ons that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine physicien end s the buriel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consaquence of): 80 ettending p signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wera autopsy findings aveileble prior to completion of cause of deeth? 24a. Was en autopsy Completed il director, page 2 s 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Deeth 28d. Describe how Injury occurred 28b Time of Certification: 28c. Injury et Work? 1 Accident 5 Pendina 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: Al completely filled in by the fu investigation 6 Could not be determined 3 Suicide

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

Medical

31. Dete filed (Month, Day, Year)

4 Homicide

29b. Signature and titla of certifier

29a. Certifier

#407 32 Registrer's Signatura

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

leted cause of death (Item 23e) (Type, Print)

Mu and

Bostimure, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

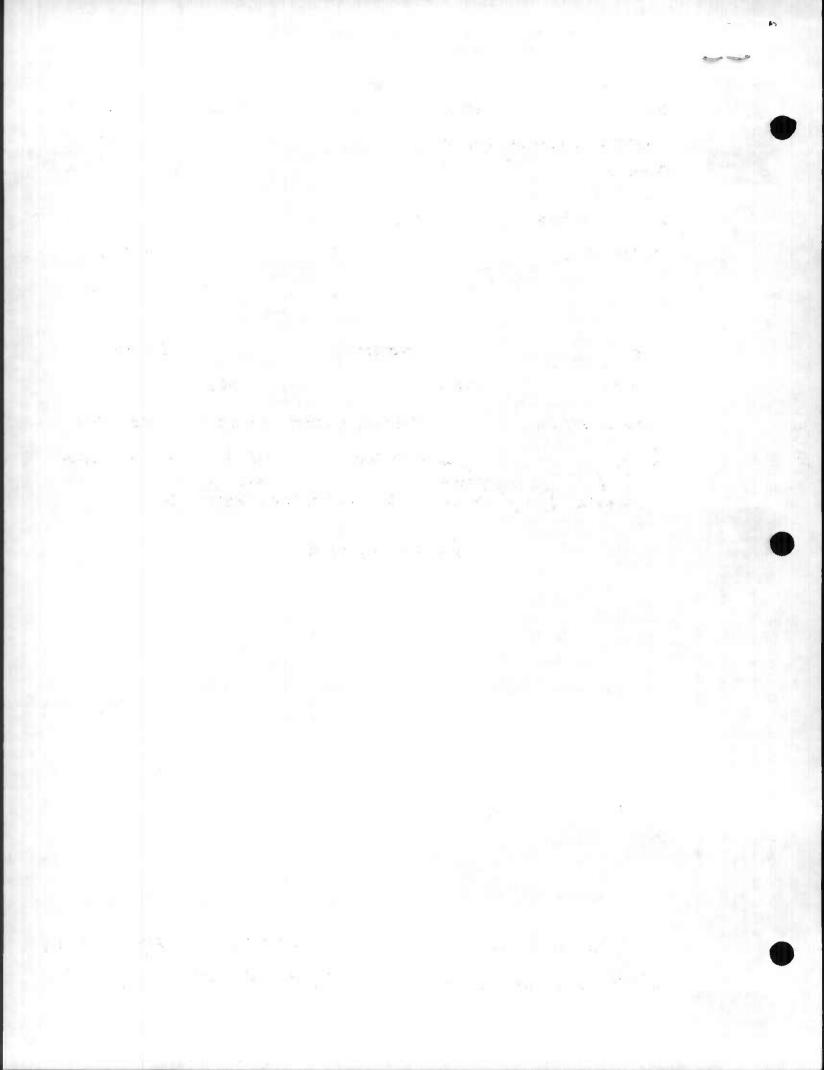
Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License numbar

00053758

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are L

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Data of Death

MARCH

8. Data of Birth

18. Mothar's Name (First, Middla, Maldan S

04-5-99

Rose Buccheri

04-10-1918

4b. City, Town, or Location of Death

TOWSON

Hours

Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.)

Specify:

Mechanic

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or

22. Name and Addrass of Facility Leonard J. Ruck Funeral Home

3113 Dubios Ave. Baltimore, Md. 21234

If Undar 1 Year | If Undar 24 Hrs.

Days

10f. Zip Coda

1 ☐ Yas 2 X No

21234

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

	giene 9 S	-	0618
nta of Do	Day	Yaar	3. Time of Death
of Dea			2:30PM
to of D		MORE	siene (Clote or Foreign
l-10-	irth a <i>y, Year)</i> 1918	Mary	placa (Stata or Foreign htry) land
		1	IOd. Insida City Limits
		-	1 ☐ Yas 2 ☐ No
	10g. Citizan of	What Cou	ntry?
	USA		
as or N atc.)		ce - Amari ick, Whita,	
	Speci	y: W	hite
	16b. Kind of E	Businass/In	dustry
		L. Mai	rtin
, Middl	a, Ma <i>ld</i> an Suma	ma)	
ri	ber, City or Town	Ctata 7i	n Code)
		ı, Stata, 24	00000)
_212 a	20c. Location	- City or To	own, Stata
5-99	Balti	more,	Maryland
	Home Inc		
oiratory	imore, 2 arrest,	1214	Approximata Interval Batween Onsat and Death

item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Example, must be notified at with 1 death Baltimore, Maryland 21215-0020 Hygiene. permit. Peges 1 and 2 should be filed Department of Health and Mental Hygi Important: If Itam 27 is marked other any Injury or other treumatic event.

Darone,

Physician

/Medical

Examiner

Funeral

Director

the Maryland

Physician /Medical Examine

certificate be executed ettending physician and for use as the bunal-trensit Box 68760. law requires that the deeth P.O. the signed by Records, been s eral Director: After this certificate has filled in by the funeral director, page 2 The Division of Vital Physician: or Attending death.

Completed Be 10 Certification: within 24 hours e Medical

Susannah M. Darrone 20e. Method of Disposition 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 23a. Part. Enter the disease, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, hock, or heary fallura. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) Examine Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disease or Injury that initiated avants rasulting in death) Last Physician/Medical Ď

1 Natural

2 Accidant

3 ☐ Suicida

4 Homicida

1. Decedant's Nama (First, Middla, Last)

T.

Baltimore

15. Decedant's Education (Specify only highast grada complated)

GREATER BALTIMORE MEDICAL CENTER

6. Sex 1 M 2 □ F

4a Facility Name (If not institution, giva street and number)

10b. County

Darrone

12. Was Dacedant Evar in U,S. Armed Forces?

MX Yes 2 No If Yas, Giva Yaar or Datas: WWII

Collega (1-4or 5+)

7. Aga (In yrs. last birthday)

Yrs.

Baltimore

Air Craft

20b. Place of Disposition (Nama of cemetery, cramatory or other place)
Holy Redeamer Cemetery

Dua fo (or es e consequence of)

Dua to (or as a consequence of):

10c. City, Town or Location

80

Joseph

219-07-5223

10e. Streef and Number

11. Maritai Status

10a. Stata

Direct

Funeral

à

Completed

Usual Basidence of Dacedent

3113 Dubios Avenue

1 Navar Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elamantery/Secondery (0-12)

Thomas Darone

17. Fathar's Name (First, Middle, Last)

19a. Informant's Neme/Ralationship (Type, Print)

Dua fo (or as a consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. CORONARY ARTERY DISEASE 25. Was cesa referred to medicel examinar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No 28a. Date of injury (Month, Dey Yaer) 27. Manner of Death 28b. Tima of 28c. injury at Work?

24b. Were eutopsy findings available prior fo 24a. Was en autopsy parformad? complation of ceusa of daath? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred 28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

deta and place, end dua to tha causa(s) and mannar as steted.

1 Yes 2 No 3 Probably 4 Unknown

29a.	Cartifiar (Check only one)	1 ☐ Certifying Physician: To the best of my knd 2 ☐ Madical Examiner: On the basis of examiner and manner stated.	
29b.	Signatura ar	nd title at certifier	29c. Licensa

nion, death occurred et the time, date and place, and dua to the ceusa(s) 29d. Data signed (Month, Day, Year)

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print) AVE. BALTO. DD 21286 515 FAIRMONT GEORGE A. BEDON

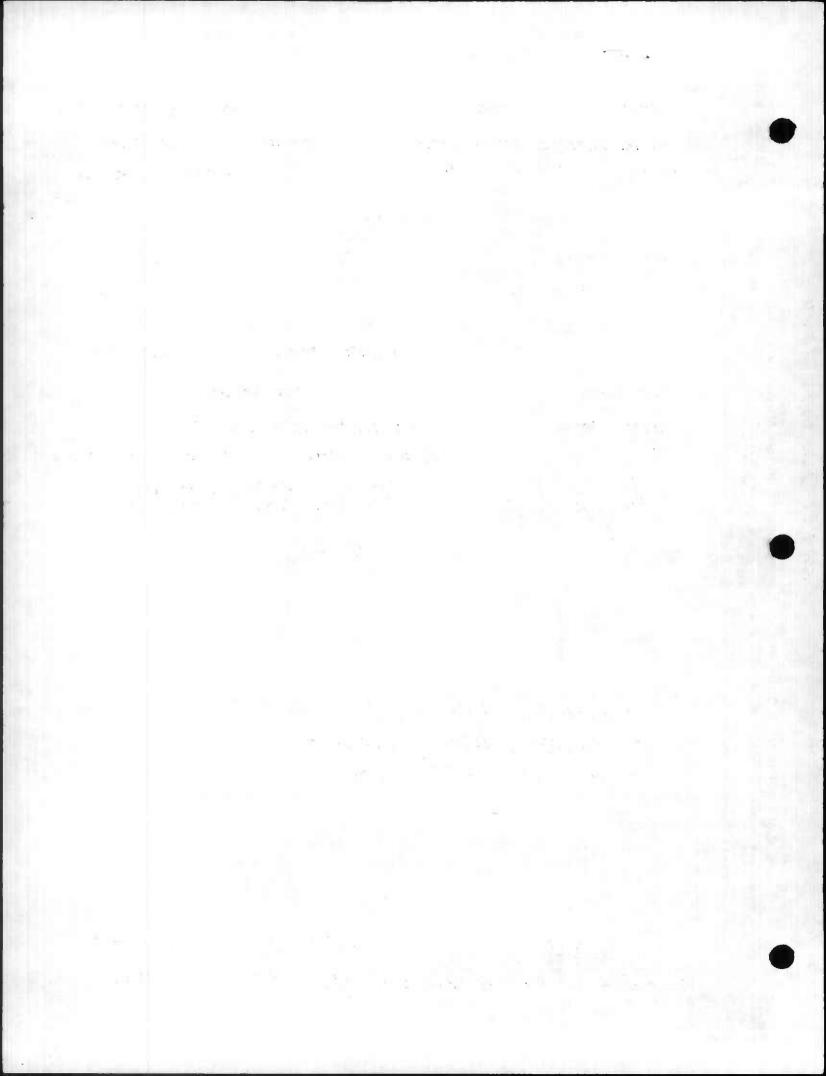
28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify)

State Registrar 31. Data filed (Month, Day, Year) APR

5 Panding invastigation

6 Could not ba

1 Tyas 2 No



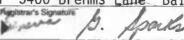
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** John Anthony Dakshaw, Jr. 12:45pm March 31, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A 3103 White Avenue 6. Sex 10 M 20 F If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 68 Yrs. 213-26-3867 Director June 6, **Usual Residence of Decedent** with the Meryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Items 23s or 28s-f show 1 Yes 2 No Baltimore City Director Md. N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21214 3103 White Avenue United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ½1 Yes 2 □ No 1948 If Yes, Give Year or Dates: 1953 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, etc. Peges 1 and 2 should be filed within 72 hours effer nant of Heelth and Mentel Hygiene.
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To the Funeral Director: After this cartificate has been signed by the estending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriahitransit completely filled in by the funeral director, page 2 should be deteched for use as the buriahitransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 ence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings availabla prior to completion of causa of daath? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Tyas 2 No 8 25. Was case refarred to medical examiner? 26. Placa of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Horna 5 Assidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Accident 5 Pending 1 Yas 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

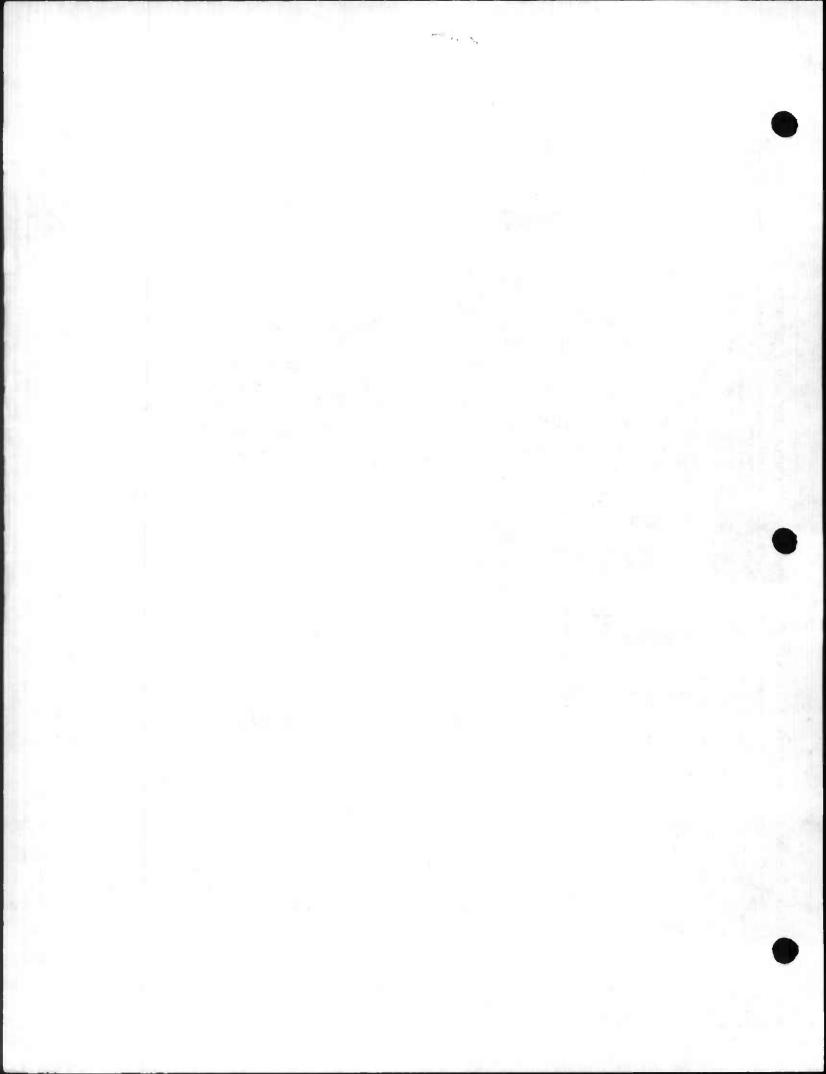
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) miran no Muchelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marguerite T. Moran 3400 Brehms Baltimore, Maryland Lane

State Registrar

31. Data filed (Month, Day, Year) 2 1999



DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month **Physician** Leonard Alvin Drechsler March 533 EMZ 30 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 622 East Marshall Avenua Deale Anne Arundel If Under 24 Hrs. If Under 1 Year 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year)
May 10,1928 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 15 M 2 F 70 Yrs. 577-34-2728 Washington DC Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show 1 ☐ Yes 2 No "natural", or items 23s or 28s-f s Director Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 East Marshall Avenue 20751 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after Nevar Married 2 Married MX as 2 No If Yas, Giva Yaar or Datas: 1950-56 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Il Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Draftsman Contracting Dearmit. Pages 1 and 2 should be filled.
Department of Health and Mental Hyginfroportant: if item 27 is marked any injury or other the page. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be William Frederick Drechsler Agnes Loraine Schrider 2 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Vickie Lynn Rankin (Niece) 2782 Cedar Drive, Riva, MD 21140 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata Cedar Hill Cemetery 04/03 Suitland, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. cerelle 14 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** Immediata Causa (Finel diseasa or condition rasulting In daath) /Medical LNSUFFICIENCY Examiner teriosclerotic Heart Disens Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, faading to immadiata cause. Entar Undarlying Cause (Disaese or Injury that initiated avents rasulting In death) Last Dua to (or as a consequence of): Box 68760. et t Dua to (or as a consequence of): P.O. Part If. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown Bypass Surgery Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yas 2 No certificate 1 □ Yas 2 □ No Division of Vital To the Hospital or Atlanding Physician: within 24 hours effar death.

To the Funeral Director: After this certifical completely filled in by the funeral director; p. 25. Was casa raferred to medicel 26. Place of Death (Check only ona) axaminar? 12 Yas 2 □ No Hospital⁻ 1 Inpatiant Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 1 Seture 5 Pending Invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the cause(s) and mannar stated. 29e. Cartifiar 29c. License number 29b. Signatura and titla of certifiar 29d. Date signed (Month, Day, Year) eparty D06054 and addrass of person who complated seuse of daath (Item 23a) (Type, Print) Jones, mo 1,111 Am 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State

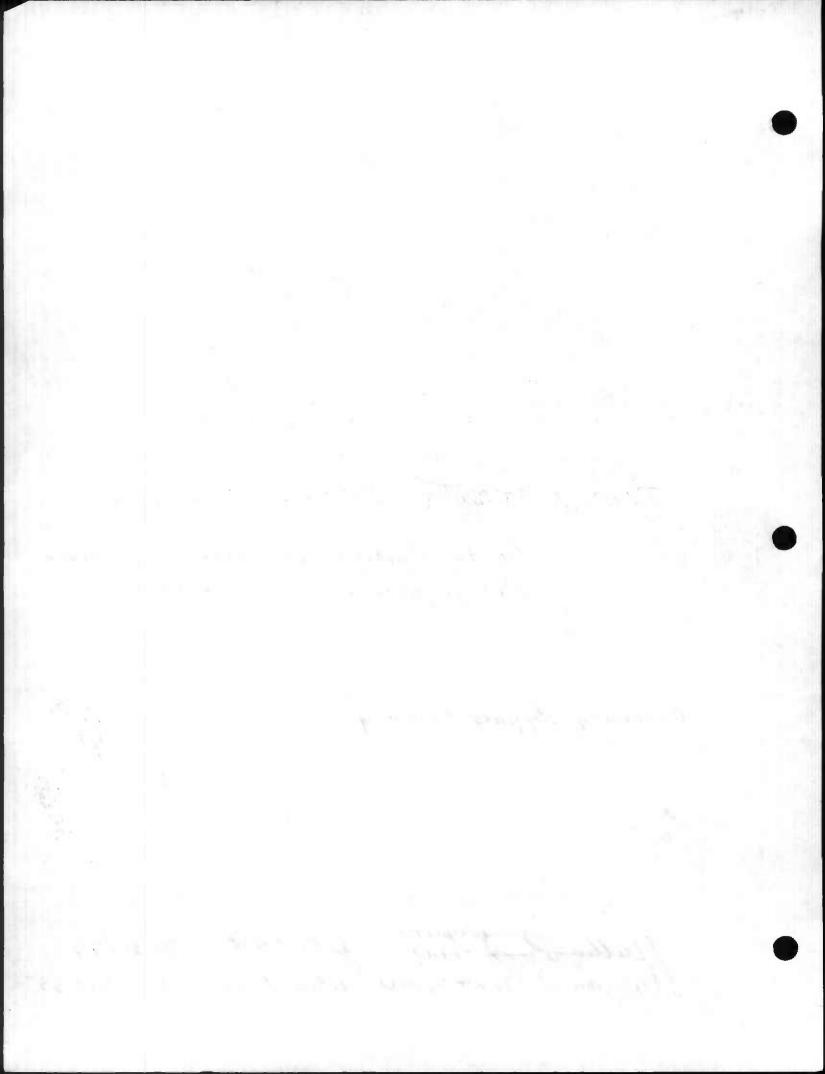
Registrar DHMH 16 Rev 6/95

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1999

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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle_Last) 854AM Mar 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Hopkins Geriatric Baltimore Center Baltimore Cit Ohns If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 75 Yrs. Days 1□ M 20 F Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Md. NIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1205 U.S.A. Streeper 606 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No tf Yes, Give Year or Dates: Specify: Afro-American 1 Never Married 2 Married 1 Yes 20 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dromestic Engineer Private Homes 5+4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Scott ela Allison 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Balto, Md. 21205 daughter 3325 McEHerry NO10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 30 199 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility ruggs Tunetal Home Calvin B. Scruggs Tunetal Home M412 E. Preston St. Balto, Md. 21: 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the dulum. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Balto, Md. 21213 Approximete Interval Between Onset and Death S'epsis Immediate Cause (Final disease or condition resulting in death) 180 Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) rovascular accident Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown dementio 24b. Were autopsy findings evellable prior to completion of ceuse of death? 24a. Was an autopsy performed? 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ∏Yes 2 ∏No

signed by the attending physician end the datached for use as the bunal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 s certificate this funeral After

/Medical Examiner

Physician/Medical Examiner Hospital or Attending Physician: I Director: A To the Hospital or Atter within 24 hours after de To the Funeral Direct completaly filled in by t

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryfen Department of Health and Mantel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1. Natural investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Yeàr)

29c. License number D04383 29d. Date signed (Month, Day, Year) March 25, 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) W.B. Greenough III MD

2 1999

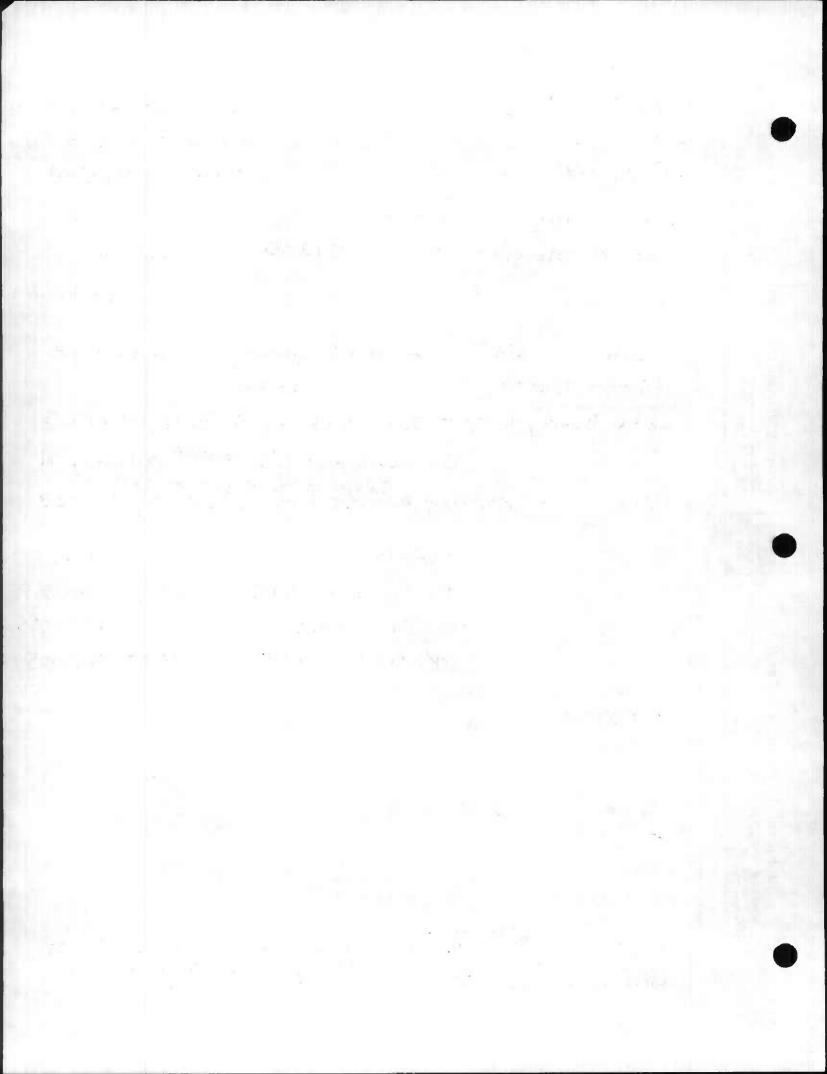
32. Registrar's Signature

5505 Hopking Baywow circle

Registrar

DHMH 16 Rev 6/95

RalT MD 21224



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#8 perFHG770 4/2/99 EW 3. Time of Death 2 Date of Deeth 1. Decedenf's Name (First, Middle, Last) Month 3:25 PM MINNIE LEE DOWD MARCH 1999 27 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 25F 92 246-09-0027 MAY \$,8 1906 NORTH CAROLINA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1511 N. LUZERNE AVENUE 21213 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 ☐ Yes 2 No If Yes, Give X 1 ☐ Never Married 2 ☐ Merried 1□Yes 2⊋No Specify: AFRO-AMERICAN 3 ₩idowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5TH N/A DOMESTIC PRIVATE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) SAM WATSON JULIA ANN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) MILDRED WAITSON/ DAUGHTER 1511 N. LUZERNE AVE. BALTO, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 20a. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CEMETERY APRIL 1,1999 BALTO, MD. 21. Son ture of Funeral Service Licensen 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications thet caused the reath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each lind. BALTO, MD. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) FIVE DAYS ASPIRATION PNEUMONIA Due to (or es e consequence of) Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequença of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FEMUR FRACTURE 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Madical Examiner must be notified at

Director

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death with the Maryland

filed within 72 hours after

al Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, the page.

altimore, Maryland 21215-0020

Examiner burial-trans Physician/Medicai the 65 ed by the a py Completed page 2 s has Be

or Attending Physician: funeral director, after death. Director: Aft the To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completaly filled in by th

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medicat examiner? 1 Yes 2 No 27. Menner of Death

1 Neturel 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifler 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

2 Pymadath MC

RES-000

MARCH 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS BAYVIEW MEDICAL CENTER

PYNADATH ELIZABETH 31. Date filed (Month, Day, Year)

32. Registrer's Signature "Admission

Registrar

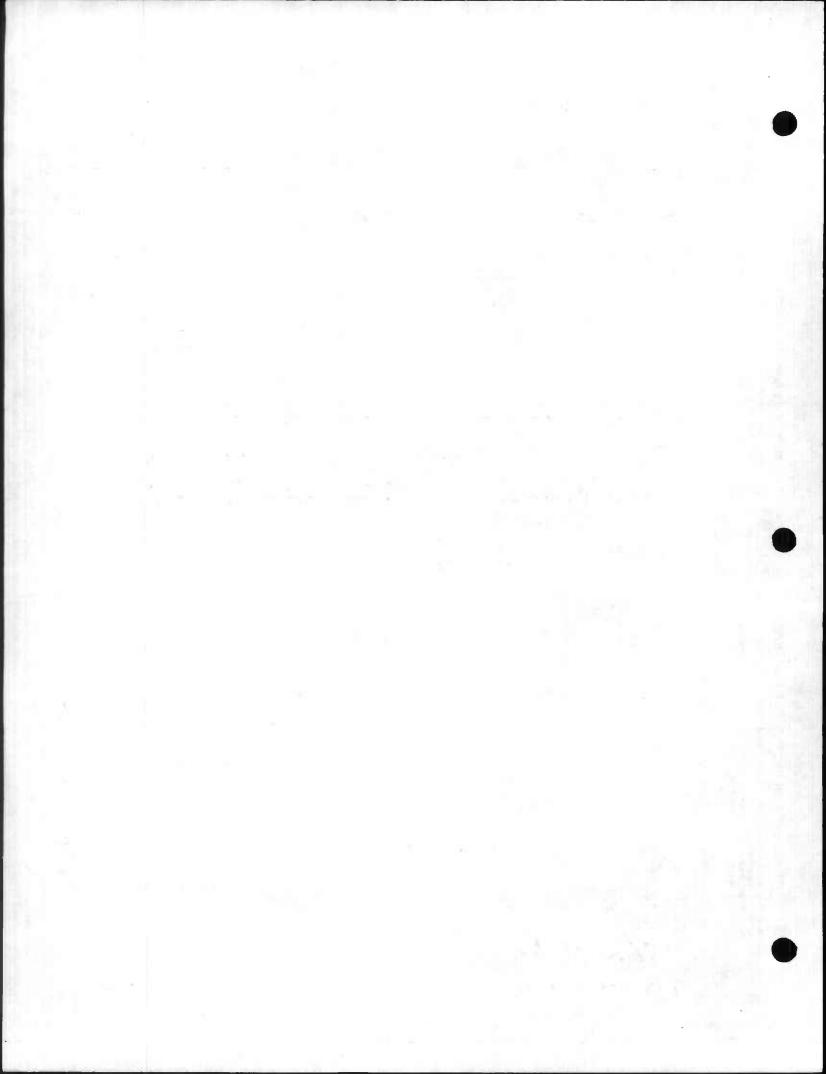
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ical ner	4e Facility Neme (If not instit			ımber)					4b. City, Tov	vn, or Lo	cation of Deat		County of D		• 10	117.
1161	121 N. EL	TWOOT	AVE.						BAT	TIM	ORE		N/F	A		
	5. Social Security Number	6. Se	0x	7. Age (In)	rs. last b	irthday)	If Under Months	1 Year Days	If Under a		8. Date of Bir (Month, Da	th v. Year)	9.	Birthplaca Country)	(Steta o	r Foraign
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Funeral	11. Marital Status		12. Was Dec	edent Evar i	n U,S.	13. W	as Deced	lent of H	lispanic Orig	gin? (Spe	ecify Yas or No Rican, etc.)	- 1	14. Race - A	Amarican I Vhite, etc.	ndien,	71.
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	ELMEA SCANLON								BERT	HA S	CHMIDT					
	19e. Informent's Neme/Rete	tionship (T	ype, Print)								al Route Numb				de)	
	ROSE MARIE MA	SZON/	SISTER	-IN-LA	W 11	3 N.	LIN	MOOI	AVE.	BAI	TIMORE	, MD	21224	1		
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month trommet hourles 29,1999 March 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death)altimore Hopkins 6. Sex 7. A Johns Hospita If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Months 1(XM 2□ F 219-32-6254 63 Yes 1936 MD. MAR. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE MD. XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 2324 E. BALTIMORE ST. 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 20 Married 1 ☐ Yes X☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUNPAPER MAIL CLERK 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARY WACHTER FRANK E. FROMMELT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2324 E. BALTIMORE ST. BALTIMORE, MD. 21224 BEVERLY ANN FROMMELT/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition BALTIMORE WASHINGTON 3/30/99 LAUREL, MD. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY 22. Name and Address of Facility 21. Signature of Funeral Service Licen CHARLES S. ZEILER & SON, INC. 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) necrotic abdomina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) axaminer? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760, or Attending Physician: Division

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Physician

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Certification: To

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29a. Certifier

(Check only one)

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29b. Signature and title of orf

/Medical

altimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) 62 Registrar's Signature 2 1999

Salazar

the completed cause of death (Item 23a) (Type, Print)

29c. License number

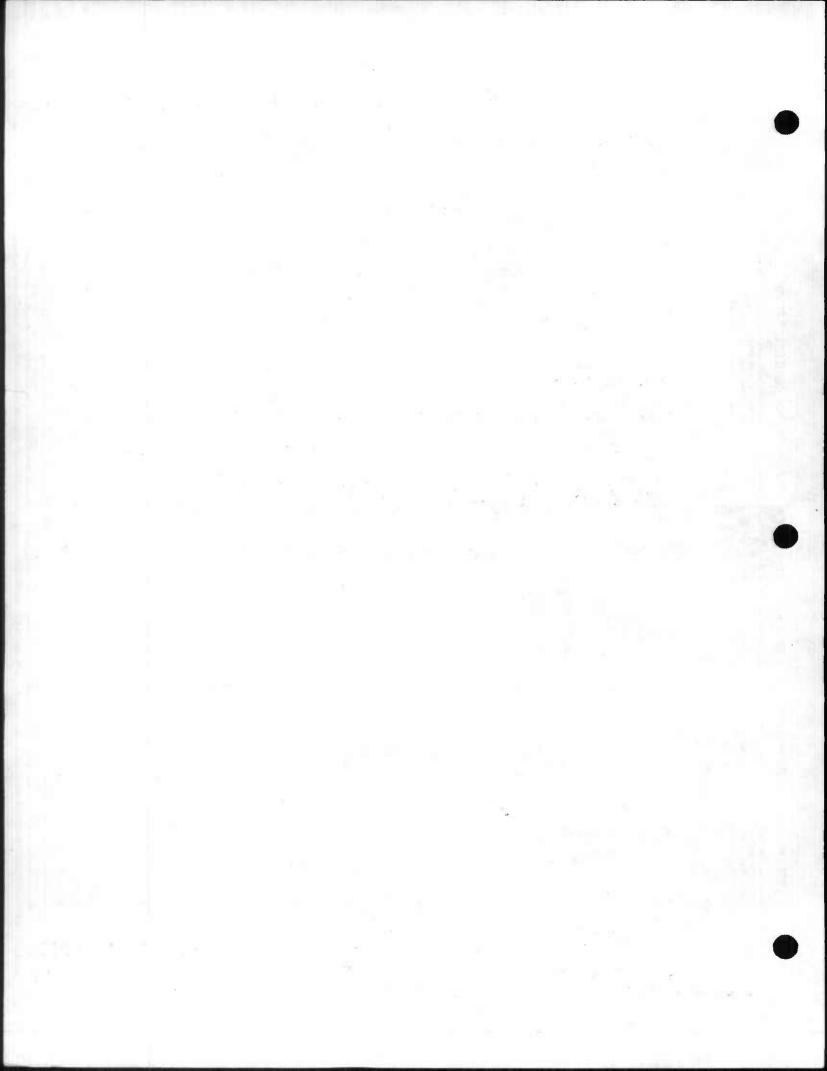
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

DES-000 600 North Wolfe Street

21287 Battimore, Mary land

MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death M X922 14 Year **Physician** -mm2 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dlumb1 MAN If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 180-01-6606 Pennsylvania Usuel Residence of Deceden the Marylend permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylen Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or itema 23s or 28a-f show with Injury or other traumatic event, the Medical Exercises must be notified at energy. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Sunbury Columbia Pennsylvania 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 17801 U.S.A 405 Catawissa Ave. Apt. 2 Funeral 13. Wes Decedenl of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Evar in U,S. Armed Forces? 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Giva altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: py Specify. 3 Widowed 4 □ Divorced White Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Beautician Beautician 17. Fathar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) Be Carrie Evert Walter Karbley 19b. Maiting Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 12865 Folly Quarters Road Ellicott City, Maryland 21042 Ms. Carole Innerbichler Daughter 20b. Ptece of Disposition (Neme of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from State
4 Donetion 5 Other (Specify) 03/31/99 Sunbury, Pennsylvania Northumberland Memorial Park 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility 1400535 Blank, Jerre Wirt Funeral Home 395 State Street Sunbury, PA 17801 23a. Pent / Entar tha disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each lina. Approximete Intervel Between Onset end Death **Physician** /Medical Immediata Ceusa (Final diseese or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of). ero dermo Box 68760 Physician/Medicai Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the causs of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown been signed t should be det py Records, 24b. Were autopsy findings sveilable prior to Completed 24a. Was an eutopsy completion of cause of death? 1 Yes 2 No al No 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Wes case raferred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation n 24 hours after deeth.

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bletchy filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homleide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signeture and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) complated cause of death (Item 23a) (Type, Print) 30. Name and address of person who Dorsey Hell Driva 801

DHMH 16 Rsv 6/95

State

Registrar

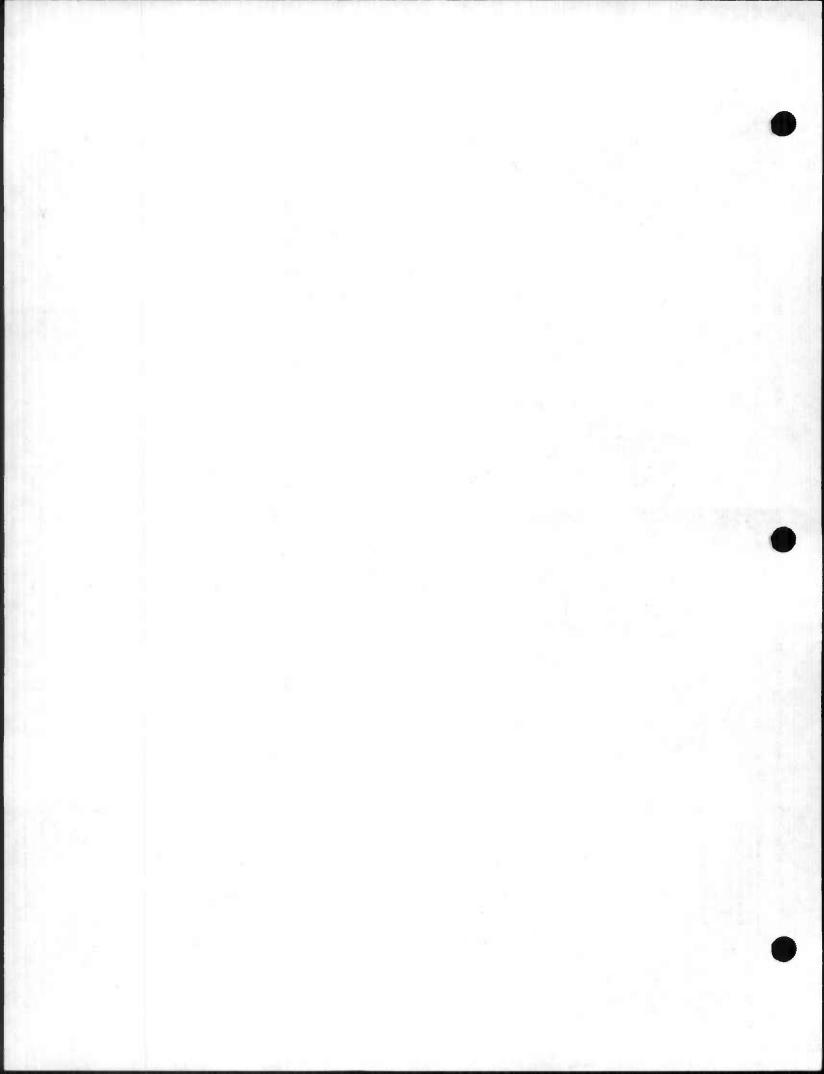
31. Date filed (Month, Dey, Year)

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1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 18, 1999 Mary S. Ferraro 1:55 PM March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien-Frankford Nursing Center Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Days 100-18-5106 90 New York Oct. 25, 1908 Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 7 is marked other than "natural", or items 23s or 28s-f sho treumstic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Maryland Baltimore Directo N/A10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21224 437 N. Lakewood Avenue U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Å No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or ite 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Specify: 2 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Meiden Surneme) Alex Santia Areminia DiSantis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Mrs. Elizabeth Wheat (dghtr) 4105 Perry View Rd., Baltimore, MD other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 🕅 Removel from State injury or Mt. Olive Cemetery 3/25/99 Hopewell. PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore,

23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Inc. 21236 Approximate Intervet Between Onset and Death **Physician** /Medical tmmediate Cause (Final Pheumonia one week disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner more than loyeurs Dementia physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Athrosclerotic Cardiovascular Disease more than Oyears Box 68760 Physician/Medical Due to (or as a consequence of) 80 Hypertension more than 20 years esn 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No þ 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24e. Was en eutopsy Completed has 1□Yes 2√No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medicel Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Naturel 5 Pending Investigation Injury efter death. Director: Aft 1□ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours e Certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) within 2.

Registrar

State

Crossroads 1999 ▶

30. Name end eddress of person who completed cause of de

29b. Signeture end title of certifier

32. Registrans Signature

Owings Mills, MD

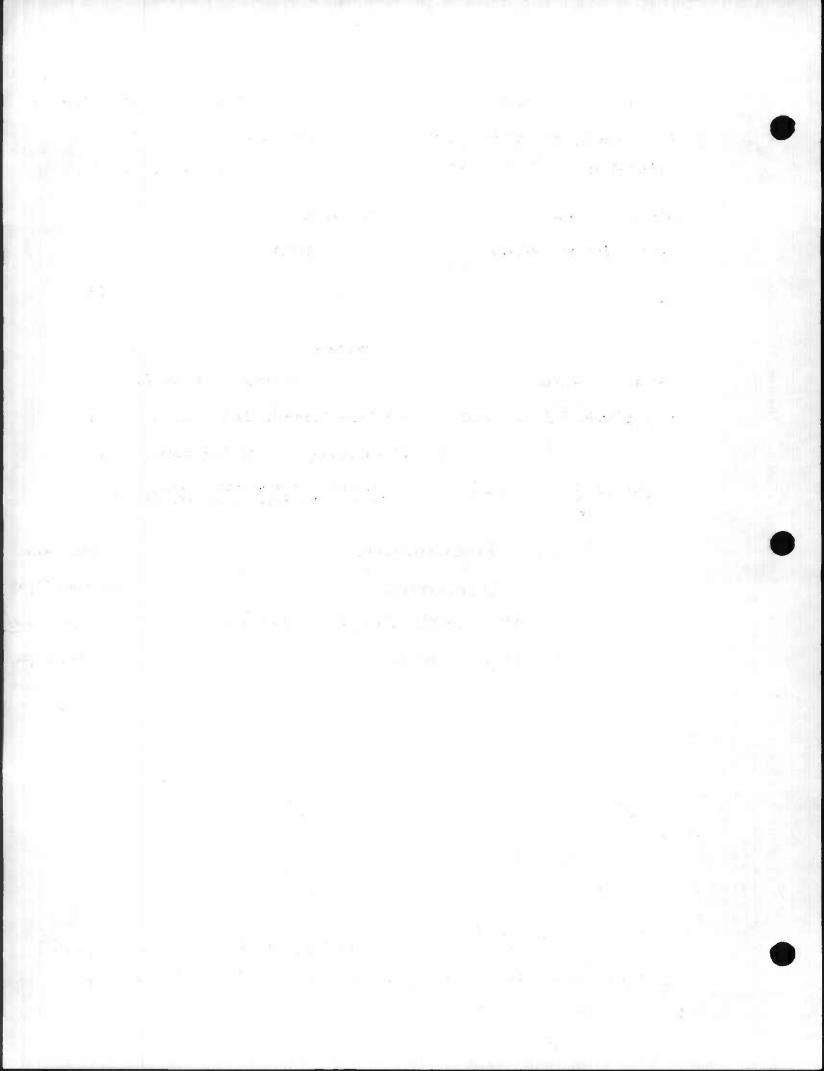
29c. License number

D0051552

29d. Date signed (Month, Day, Year)

March

DHMH 16 Rev 6/95

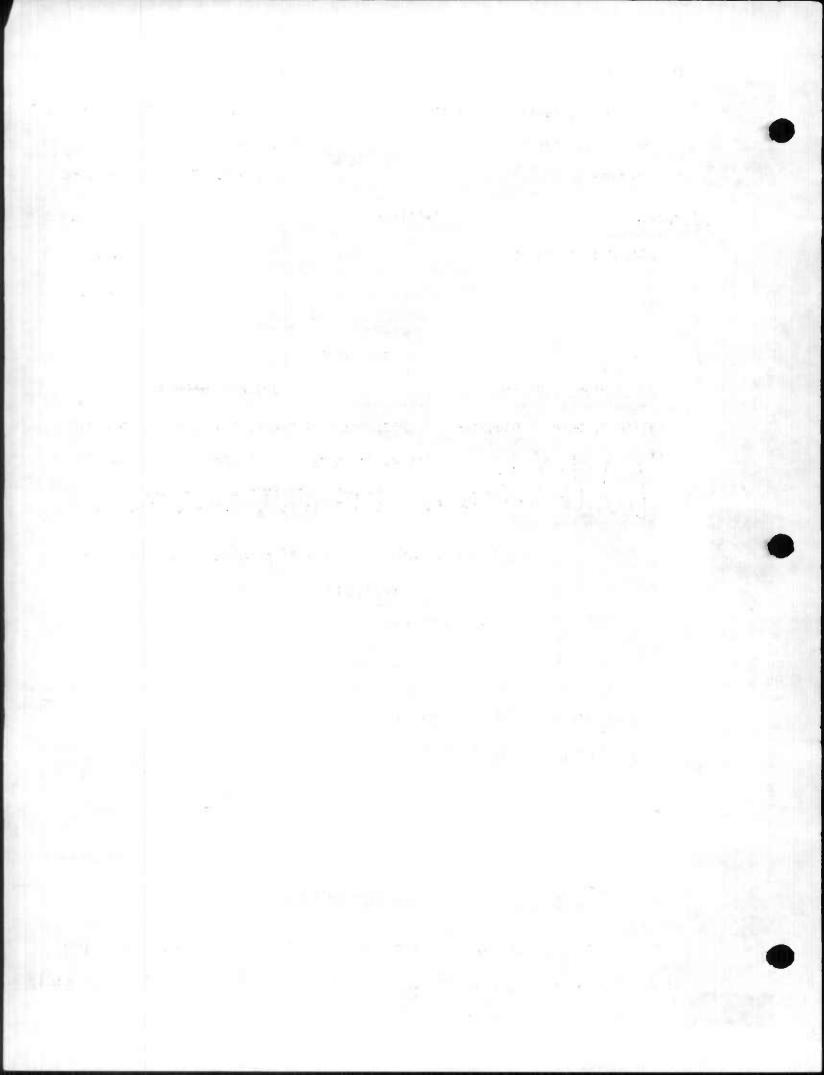


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 18 per F.H G-700 4/13/99 reb Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day **Physician** March 31 4b. City, Town, or Location of Death 1999 02:13 PM Pearl Estelle Frederick /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number, Examiner Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 3608 Hooper Avenue If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 M & F Yrs. Director Oct. 17, 1923 Maryland 213 20 1454
Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10b. County 10c. City. Town or Location XX Yas 2 No Baltimore Directo Maryland N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "natural", or items 23a or adical Examiner must be n 3608 Hooper Avenue 21211 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas XX No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. hours after 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas ⊋ No Specify: Specify: White g 3 XVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) Sled within 72 Coltega (1-4or 5+) the st Etemantery/Secondary (0-12) and Mental Hygiene, is marked other than Homemaker In Own Home 8 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be tilt Department of Health and Mental Hi Important. If then 27 is merked oth any injury or other traumatic even Margaret Robb Reeb 2 Marion S. Basford 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Sallie M. Geer Daughter 2821 Graybill Court, New Windsor, MD 21776

20b. Place of Disposition (Name of cametery, cramatory or other place)

20c. Location - City or Town, Stata 20a. Method of Disposition 1 Buria 2 Cramation 3 Removal from State 4 Docation 3 Other (Specify) Weisburg Cemetery Monkton, MD 4/3/99 22. Nama and Addrass of Facility Burgee-Henss Funeral Home, P.A. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac of respiratory arrast, a linear later of heart failure. List only one hause on each line.

3631 Falls Road Baltimore, MD 21211 Approximate Interval Batween or heart failure. List only one hause on each line. **Physician** /Medicai Immediate Causa (Final disease or condition rasulting in deeth) atherosclerotic coronary Vascular disease Examiner Dua to (or as a consequence of): Physician/Medical Examiner iabetes melli and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Causa (Disaasa or Injury Due to (or as a consequence of) physician ar s the buriel-t Division of Vital Records, P.O. Box 68760, pertension that initieted avents rasulting in death) Last Dua to (or as a consaquance of): for use as 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown heart +AI Lure signed I by 24b. Wara autopsy findings available prior to complation of ceusa of death? Completed 24a. Was an autopsy VASCULAY cartificete has b 1 Yas 2 No 1 Yas 2 No or Attending Physician: 25. Was cese referred to medical axaminar? Be 26. Piece of Death (Chack only one) Hospital: Othar: 4 Nursing Homa 9 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance 6 □Othar (Specify) : After this direction 28a. Deta of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Natural 5 Panding To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu 1 Yas 2 No invastigation 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicide edical 29a. Certifiar 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, data and place, end due to the ceuse(s) and mannar es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end piece, end due to the ceusa(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number mo Marin 30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) Baltimore DON M.D Maryland brehms ANE 400 HILARY 31. Data filed (Month, Day, Year) 32. Registrar's Signatura 1999 Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** (0 /Medical 4e. Facility Nema (If not institution, give street and number) 4b_City, Tows, or Location of Death 4c. County of Death Examiner 5. Social Security Number 7. Aga (In 6. Sax last birthday) Birthplece (Steta or Foraign Country) **Funeral** Sax 1□M 2DF Days Director the Maryland 10e. Stata 10b. County 10c. City. Town or Location IOd. Insida City Limits 28a-f show the Medical Examiner must be notified at Baltrure TE Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? or items 23a or filed within 72 hours after death with U5A INGShipy 21218 Funeral 12. Wes Decedant Ever in U,S. Armad Forces?1 ☐ Yes 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status Navar Married 2 Married 1 Yas 2 No Specify: Black by Specify. 3 Widowad 4 Divorced "natural" Completed 15. Dacedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life., DO NOT usa refired) 16b. Kind of Businass/Industry i Hygiene. DUN HOME Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Home mptor 4 GARS Department of Health and Mental Hygis Important: If item 27 is merked other t any injury or other traument Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnema) Be JURDAN Durothe KESSIE (rapy 0 19a. Informant's Name/Raiationship (Typa, Print) 19b. Mailing Addrass (Street end Number or, Flural Route Numbar, City or Town, Stata, Zip Coda) Chelle Cotor WHIGH, Hary low 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Locetion - City or Town, Stata Buriai 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) U Alley 22. Name and Addrass of Facility // Amush 21. Signatura of Funaral Sarvice Licensee REISTERATION PA 48 23a. Part1 Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. der Approximata ntarval Batween Onset and Deeth **Physician** Immediete Ceusa (Final disease or condition rasulting in daath) /Medical Retroperitonea **Examiner** Intrarenal hemorrhage in The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Disaasa or injury thet initiated avants rasulting in daeth) Last Dua to (or as a consequence of). Coagulopathy
Due 10 (or as a consequence of): Division of Vital Records, P.O. Box 68760, Week Physician/Medical months oumadin Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown Stroke þ 24b. Wera autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? foramen of ovale Patent 2 No 2 No the Hospital or Attending Physician: 25. Was cese rafarred to medical axaminer? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred After t 5 Panding invastigation death. 1 🗌 Yas 2 🗌 No Accidant I Director: A 6 Could not ba 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours eff To the Funerel Di completely filled in 29a. Certifier Cartifying Physician: To tha best of my knowladga, deeth occurred at tha time, date end piece, end due to tha ceusa(s) end menner es steted.

2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) end manner state. 29b. Signature and titla of certiliar 29c. Licansa number 29d. Date signad (Month, Day, Year) D0046907 03, 24, 1999

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State Registrar

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30. Name and odress of person why con

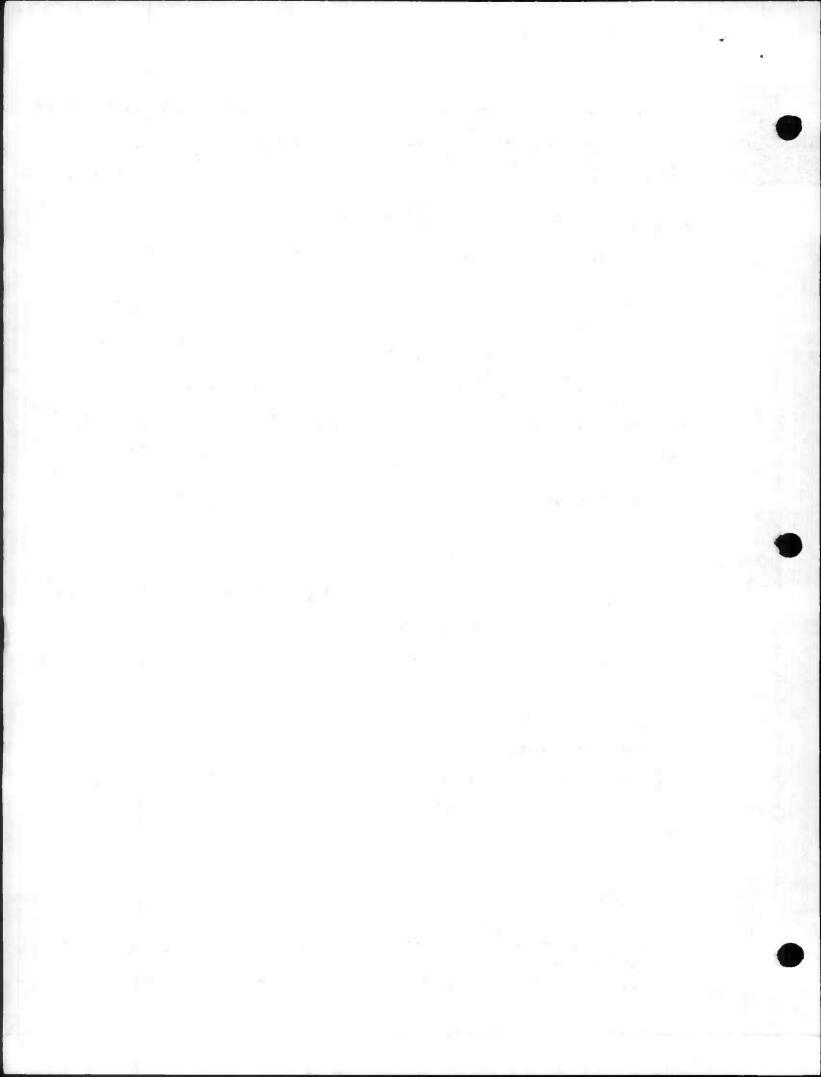
Day, Year) 32. He

Raven Blvd
32! Gegistrar's Signatura

pleted causa of deeth (item 23e) (Typa, Print)

Sporks

Suite 208, Baltimore, MO 21239



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:50AM ELSA ROSE GRASER April 1, 1999 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) 319 Homeland Southway Apt 3B Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. SEPT. 24 If Under 1 Year 9. Birthplace (State or Foreign Country) PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. lest birthdey) 2°°1'908 1 □ M 2 □ F Months Deys 90 Yrs. 215-34-3498 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 HOMELAND SOUTHWAY APT. 21212 U.S.A. 14. Raca - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) EDUCATION EACHER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) THEODORE GRASER SR. CAROLINE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) PER. REP. 210 N. CHARLES STREET SUITE 800 BALTO. MD. WENDY WIDMANN 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GREENMOUNT CREMATORY 4/2/99 BALTIMORE, MARYLAND 21. Signature of Funeral Servica Licansee 22. Name and Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. do 23a. Part1. Enter the disease, or complications that caused by deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each limit of the mode of dying, such as cardiac or respiretory errest, 6500 York Road Baltimore, Maryland 21212 Intervel Between Onset and Deeth In Carcinon Immediete Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: **Physician**

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permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises

Physician

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31. Dete filed (Month, Dey, Year)

29b. Signature and title of certifier

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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

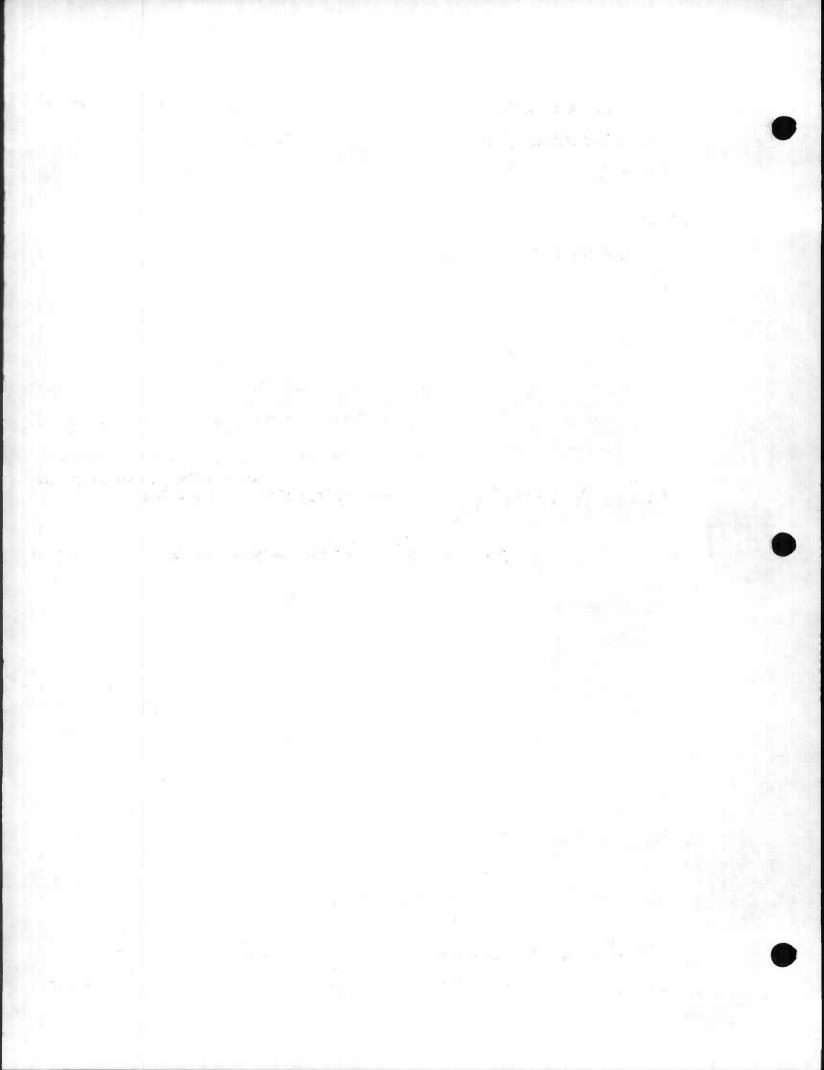


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1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner as stated.
2 Wedicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end pleca, and due to the ceuse(s) and menner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

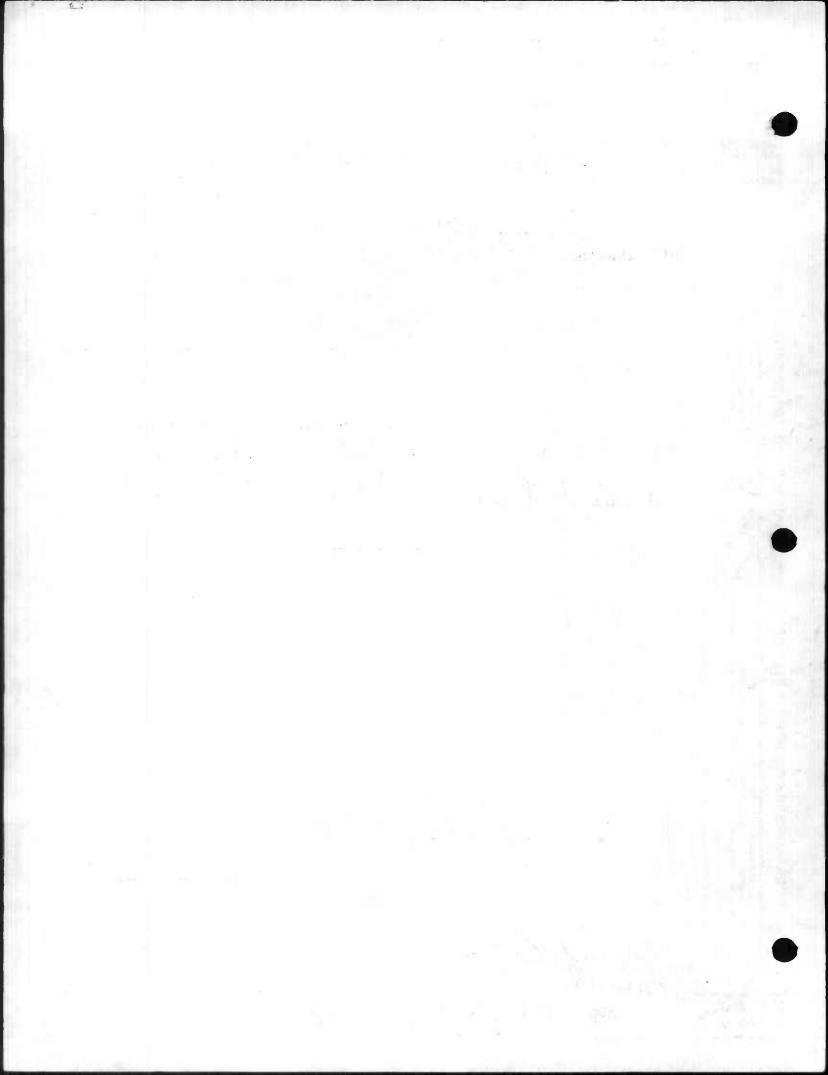


State Registrar

THEODORE MIKE. 31. Dete filed (Month, Day, Year) APR 5

40 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #20B-C PER F.H. G770 4-2-99 WR. 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Daath March 26 MILDRED GRIFFIN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) paryland reneral If Undar 1 Yaar If Under 24 Hrs. 5. Social Security Number 6 Sav 7. Age (In yrs. lest birthday) 9. Birthplaca (Stete or Foreign MD. Months Days Hours 1□M 2♥F 214-20-0858 Usual Rasidence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number U.S.A. 21217 2210 LINDEN AVE 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ď No If Yas, Giva Year or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. 13. Was Dacedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11. Marital Status 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 No Specify: Specify: BLACK 3 □ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Collaga (1-4or 5+) Elamantary/Secondary (0-12) HOME HOUSEKEEPER 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) JOHN C. CHEEVES ANNA JOHNSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2210 LINDEN AVE BALTIMORE MARYLAND. 21217 BENNETT CAVANOUGH 20b. Place of Disposition (Nama of cometent), crematory or other place; ARBUTUS CEMETERY LOUDEN PARK CEM. 20a. Method of Disposition XBurial 2 Cremation 3 Removal from Stata 4-1-99 BALTIMORE MD. PARK CEM. 4 Donation 5 Othar (Specify) 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE. BALTIMORE MD. 21217 23a. Part 1. Enter the disaasa, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) monia Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of ceuse of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 DInpatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Yaar)

Examiner Examiner physician end the burial-transit certificata be exec Physician/Medical 88 USB Po datached signed b Division of Vital Records, by Completed page 2 s cartificate Hospital or Attending Physician: funeral director, Be P this Certification: Aftar 24 hours after death.

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1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certified

Day.

^{Yaar)} 1999

29c. License number

29d. Data signad (Month, Day, Year)

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32. Ragistrar's Signatura

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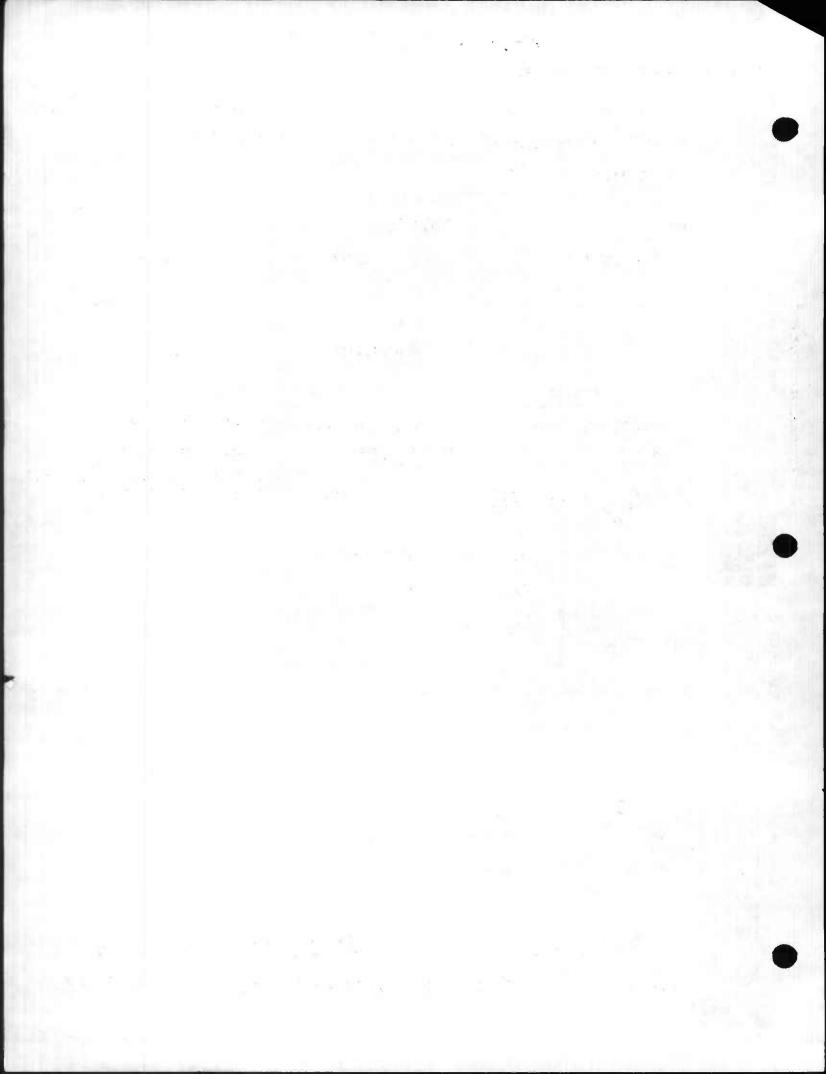
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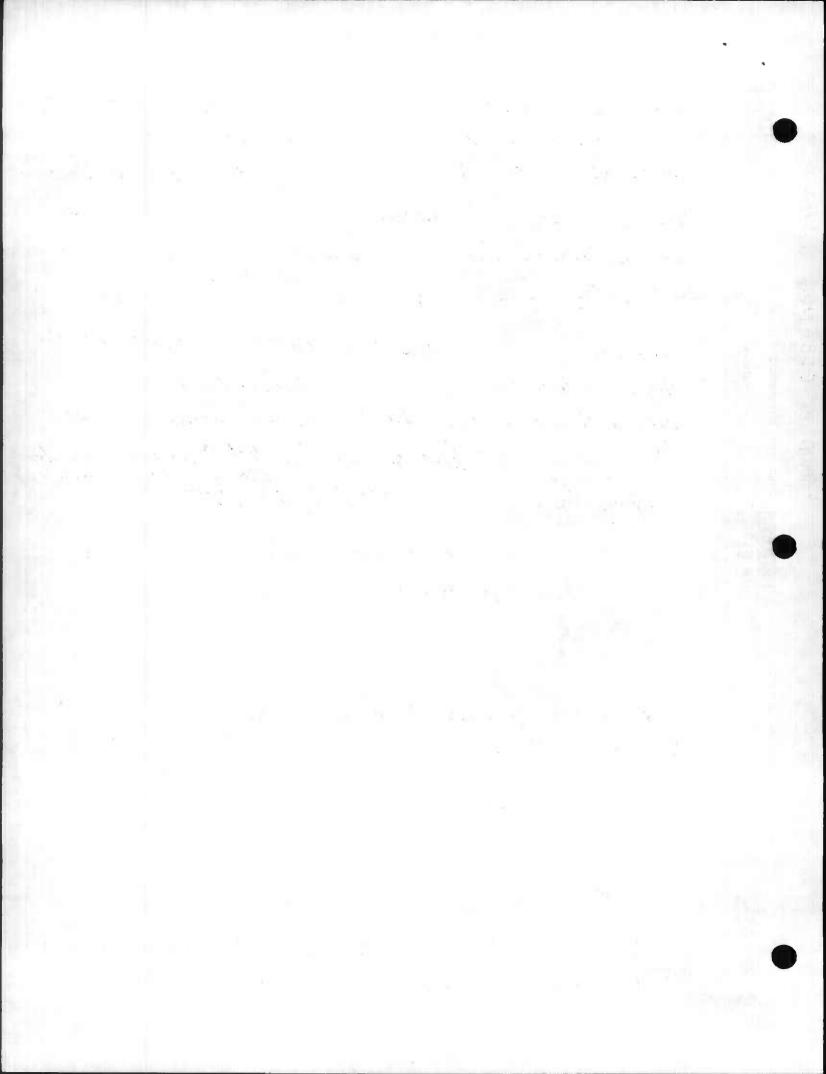
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month 3:55 AM March 31 HOLLAND MAE 4e. Facility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Deeth Glen Burnie North Arundel Hospital If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) MAY 3, 1925 Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthpiece (Stete or Foreign Country) Days Months Hours 1□M 20 F 73 Yrs 526-36-5493 MAINE Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 124 PATRICIA AVENUE U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 Yes 2√2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY WESTINGHOUSE 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) WELCH CONEY SYLVIA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JAMES PATRICK HOLLAND (HUSBAND) 124 PATRICIA AVENUE, LINTHICUM, MD. 21090 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 3/3^{Date}99 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER LLC STEVENSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Onset and Deeth Immediate Cause (Final NEUMONIA disease or condition resulting in death) SYSTEMIC LUPUS ERYTHEMATOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? SOUT 20 No 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INd 1☐ Impatient 2☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier

The law requires that the death certificate be executed Box 68760 o ۵. Records, Division of Vital Hospital or Attending Physician: hours efter death. uneral Director: A sly filled in by the fo death. To the Hospital o within 24 hours eff To the Funeral Di completely filled in

Physician

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State Registrar

31. Date filed (Month, Day, Yeer) 2 1999

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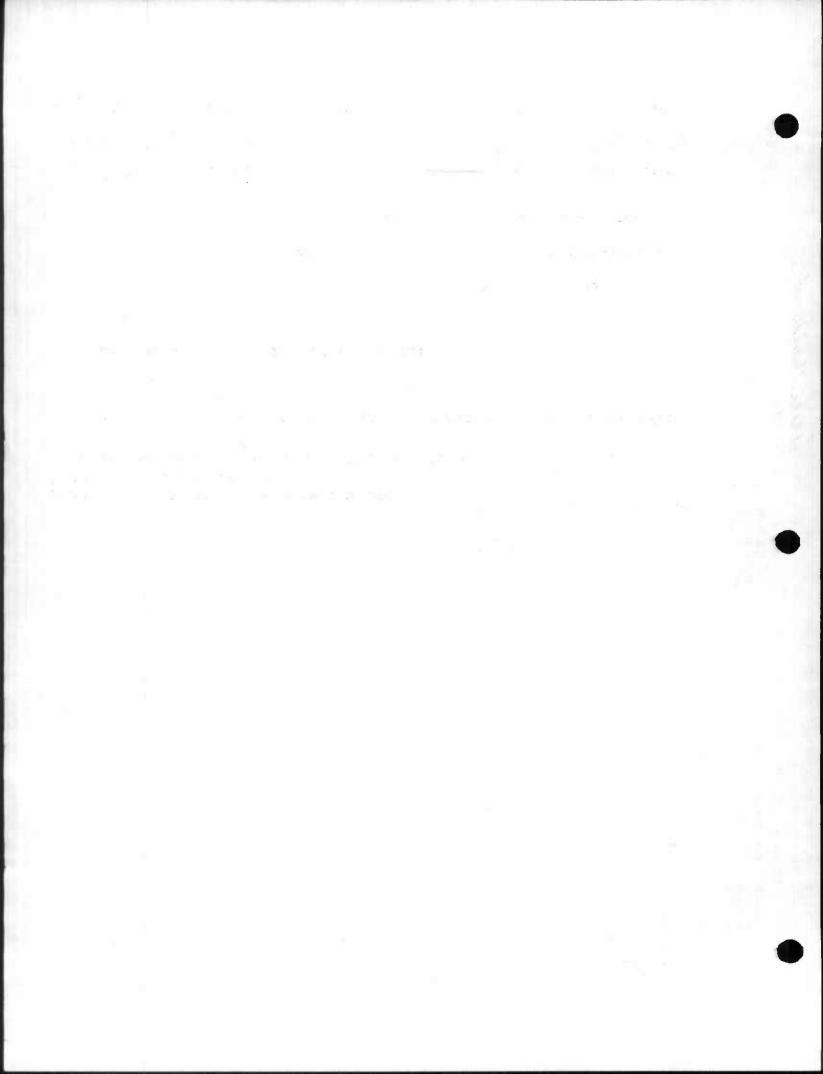
son who completed cause of deeth (Item 23a) (Type, Print)

ARONDER HISPITAL - MD

29c. License number

51245

29d. Date signed (Month, Dev. Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** RICHARD LaDELLE HALL April 1, 1999 9:20AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner College Manor Lutherville Baltimore Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 1912 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2□ F Yrs 215-03-3151 Director Maryland **Usual Residence of Decedent** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes ZXX No Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 West Seminary Avenue 21093 USA death Funeral 12. Was Decedent Ever in U,S. Anned Forces? 1 WVes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite may highly or other traumatic event, the Medical Examina page. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2() No Specify Specify: White py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postmaster **US** Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alfred Richard Hall Sadie Estelle Chenworth 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara H. Gunkel DTR 10254 Arizona Circle Bethesda Maryland 20817 20b. Place of Disposition (Name of cemetery, crametory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 (C) Cremation 3 ☐ Removel from State Greenmount Cemetery 4/2/99 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland ature of Funeral Service Liganson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 workes ed the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, 23a. Pent1. Enter the disease, or complication hat causshock, or heart failure. List only one cause on each Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER /Medical Examiner Physician/Medical Examiner physician end s the burial-transit that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or es a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part It. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, p 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 1□Yes 2☑No Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, I Be 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1□ Yes 3☑ No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28c. Injury at Work? 27. Manngs of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, term, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number D-50242

State Registrar

2 1999

31. Date tiled (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ursula McClymont MD 3333 North Calvert Street Baltimore, Maryland 21218

April 1, 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William M. Hash 31, 1999 March 11:50 PM /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Manor Care Towson Nursing Center Towson Baltimore if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 27, 1916 Birthplace (State or Foreign Country) 6. Sex 1 N M 2 □ F Months Days Hours Min Yrs. 82 236-05-3577 Virginia Usual Residence of Decedent 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Upper Falls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11535 Franklinville Road U.S.A. 21156 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify by 3 D Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Grade College (1-4or 5+) Proprietor Dry Cleaning 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Ida Mae Blevins Issac Lon Hash 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Heathrow Manor Court, Balt., MD 21236 Mrs. Mildred L. Law (dghtr) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem'l Gardens 4/6/99 Baltimore. Maryland 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD Schimunek Funeral Home, In 9705 Belair Rd., Baltimore

23a. Part. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. 21236 Approximate Intarval Between Onset and Death A Cute Pulmoner Immediate Cause (Final ours disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Sevore walnutrition ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was cese rafarred to madical examiner? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Alatural 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be axecuted P.O. Box 68760. Hospital or Attending Physician: aftar death. Director: Aft

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Menyland neat of Heelih and Mental hyglene. In: If feer a 21s or 28s-f show mit: If feer 27 is merked other than "haturel", or ferme 23s or 28s-f show iny or other treumstic event, the Medical Experiment must be notified at

Physician /Medical

Examiner

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After this certificate has funeral director, page 2

Baltimore, Maryland 21215-0020

Division of Vital Records, To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

> State Registrar

Medical

29a, Cartifiar

29b. Signature and title of certifier

FAHED KOULIM.D

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print) Drive Suite . Osler 600

203 TOWSON MD 21204

32. Registrat's Signature 31. Date fited (Month, Day, Yaar)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death 703 March pm Audreu M. Hinkel 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Fallston General Hospital Fallston Harford Hours Min. 8. Date of Birth (Month, Dey, Yeer) Aug. 22, 1 If Under 1 Yaar Birthplece (Steta or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthdey) 1 M 2 X F Deys Months 1921 219-03-0570 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3504 Cliftmont Avenue 21213 U. S. A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merriad 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Administration 12th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Arthur Gray Ina Esther Pardue 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Janice L. Stump (Daughter) 7 Stagecoach Road, Cumberland, Rhode Island 02864 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Buriel 2 Cremetion 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4/2/99 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signeture of Funeral Service Licensee Jodac 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. CONTESTIVE HEART Immediete Ceuse (Finel 8 ymonths diseese or condition resulting in death) Due to (or as e consequence of): VIRAL royears CARDIONY OPATHY Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were eutopsy findings availebla prior to completion of ceuse of deeth? 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 Synpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 THomicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29a. Certifier (Check only one)

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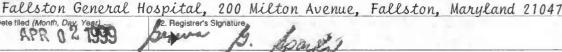
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31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier



(Jassar

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)



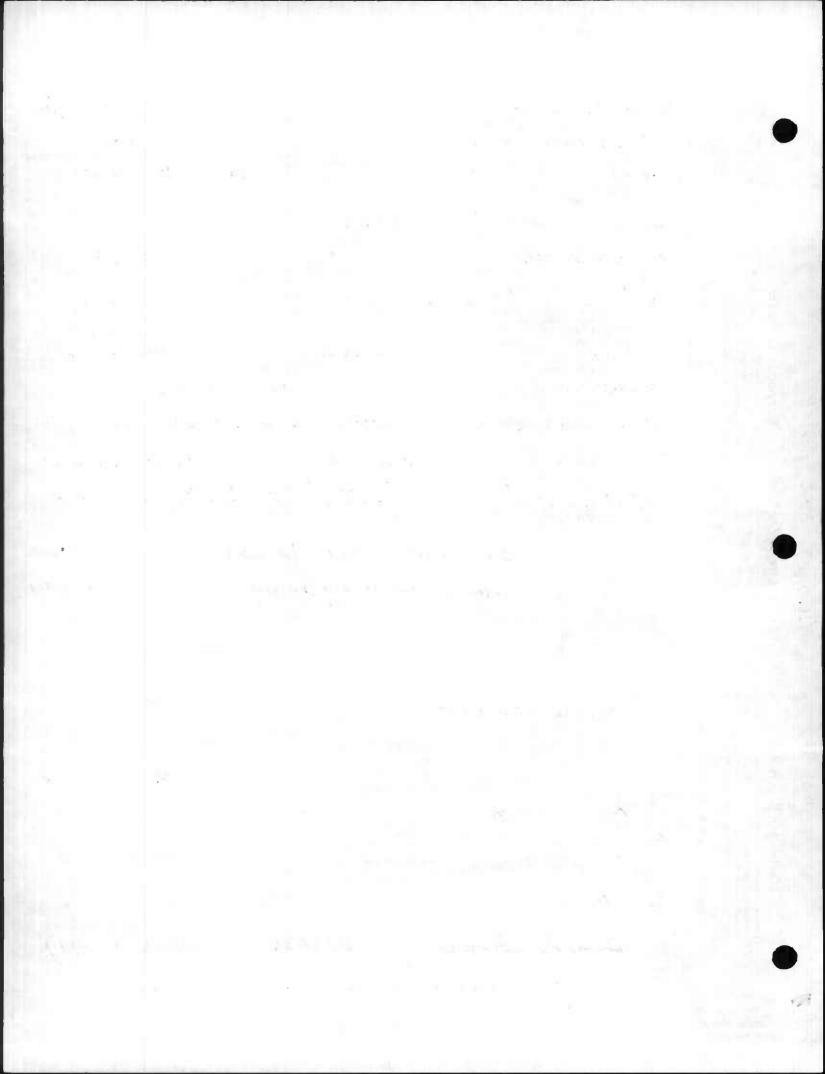
29c. License number

216036

29d. Data signed (Month, Dey, Year)

APRIL

Dean L.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0637 Certificate of Death Item#11 perFH G770 4/9/99 EW 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Nema (First, Middla, Last) **Physician** reraldine Hawkins 0839 MARCH 29 rances /Medical 4b. City, Town, or Location of Daath 4e Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner illa Baltimore St Michael 8. Date of Birth (Month, Dey, Year) 9-24-19 If Under 1 Yaar | If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 M 20 F Months Deys Hours Min 86 DC 578-20-0594 Yrs. Director Usuel Residence of Decedent 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Ma Batimore Director NA traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 11.J.A Road 4137 ax Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. Never Married 2□ Married 1□ Yes 2X No Specify: Black Aq 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Harbor College (1-4or 5+) Elementary/Secondery (0-12) 2th grade reamstress NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Mental Corner men Mary Lo 19a. tntorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If hem 27 is Mildred 209 Chatham Balto, ma How Kins - Daughter Odd Baltimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Crametion 3 ☐ Removal from State 6 Memorial 4-2-99 Hank 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Do HO Md Livenue Approximeta Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) YWEEKS . IEND STAGE DILATED CARDIOMYOPATHY Examiner Examiner ATHEROSCLEMOTIC CAMDIOVASCULAR DISEASE physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consaquance of): ettending signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uea contributa to the causa of death? P.O. 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION Division of Vital Records, 2 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy periomad? MULTIPLE AORTIC ANEURYSMS hes 1 Yes 2 No 1 Yes 2 No Be 25. Wes cese reterred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner ot Deeth 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation 1 Matural death. 1 Yes 2 No 2 Accident or Attend after death Director: A To the Hospital or Atterwithin 24 hours after dea To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyaiclan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number March who completed ceuse of deeth (Item 23e) (Type, Print) 30. Nema and address of person 7220 Park Heights Avenue DEBORAH PIERCE Baltimore, MD 21208

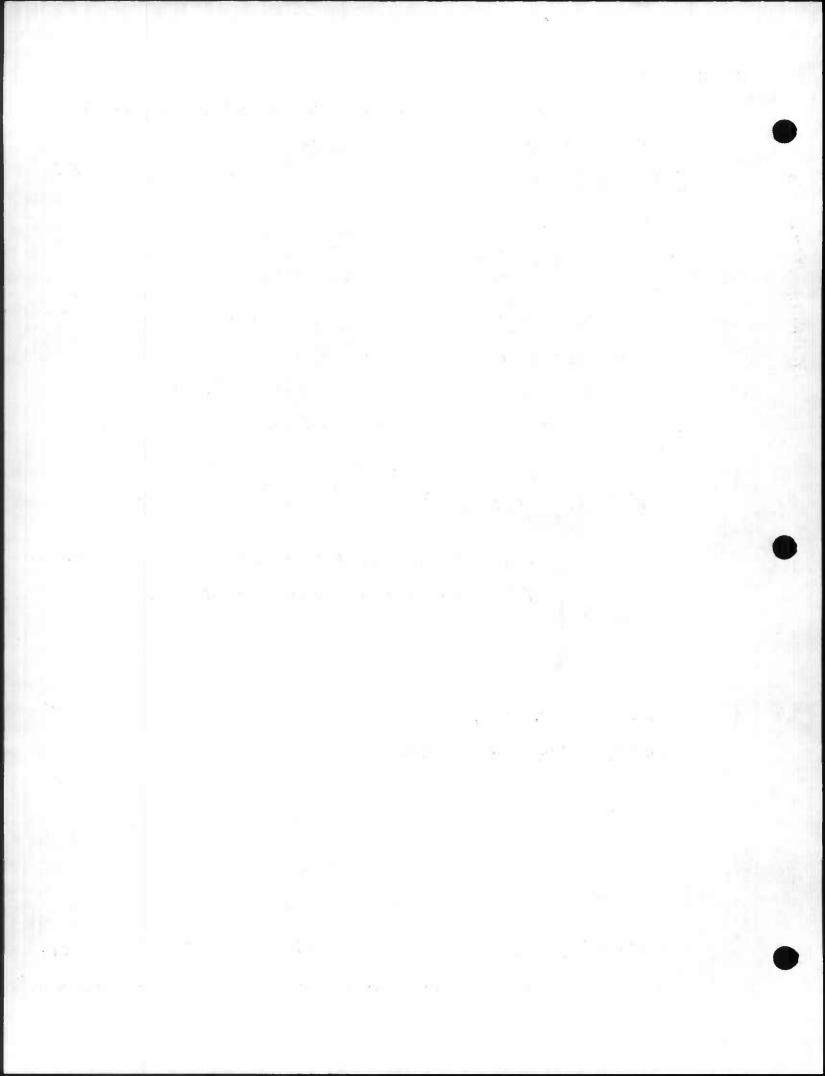
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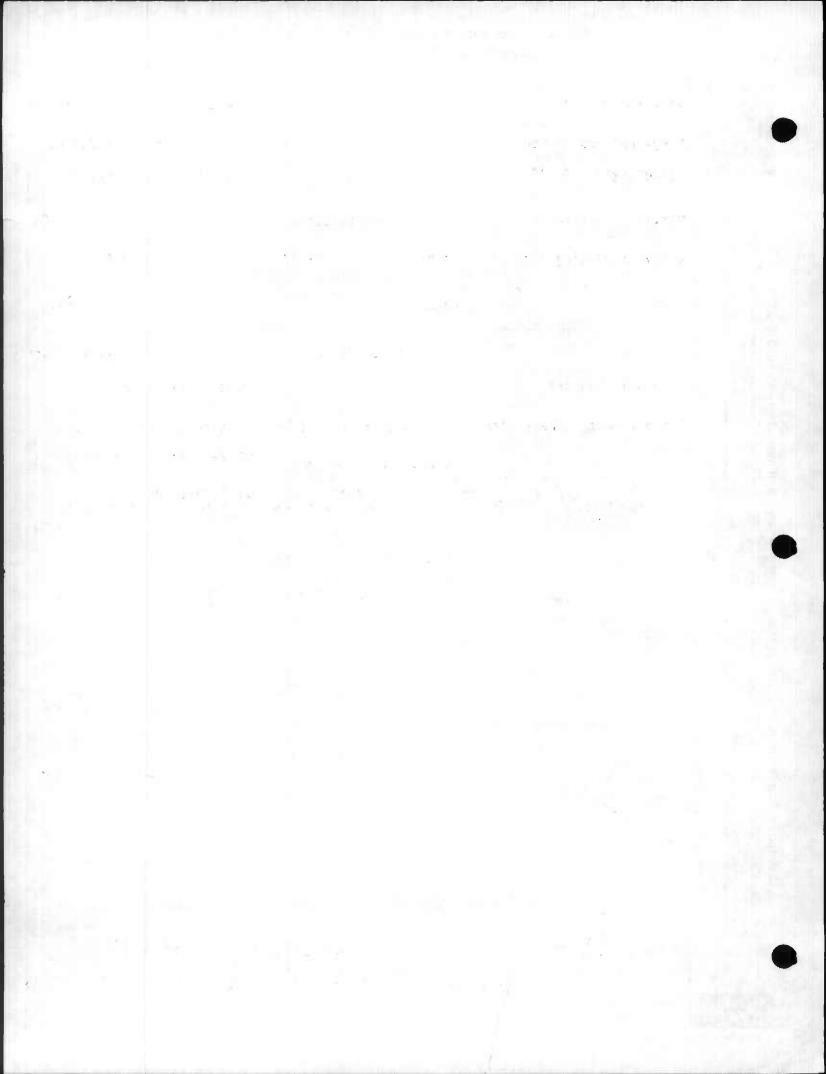
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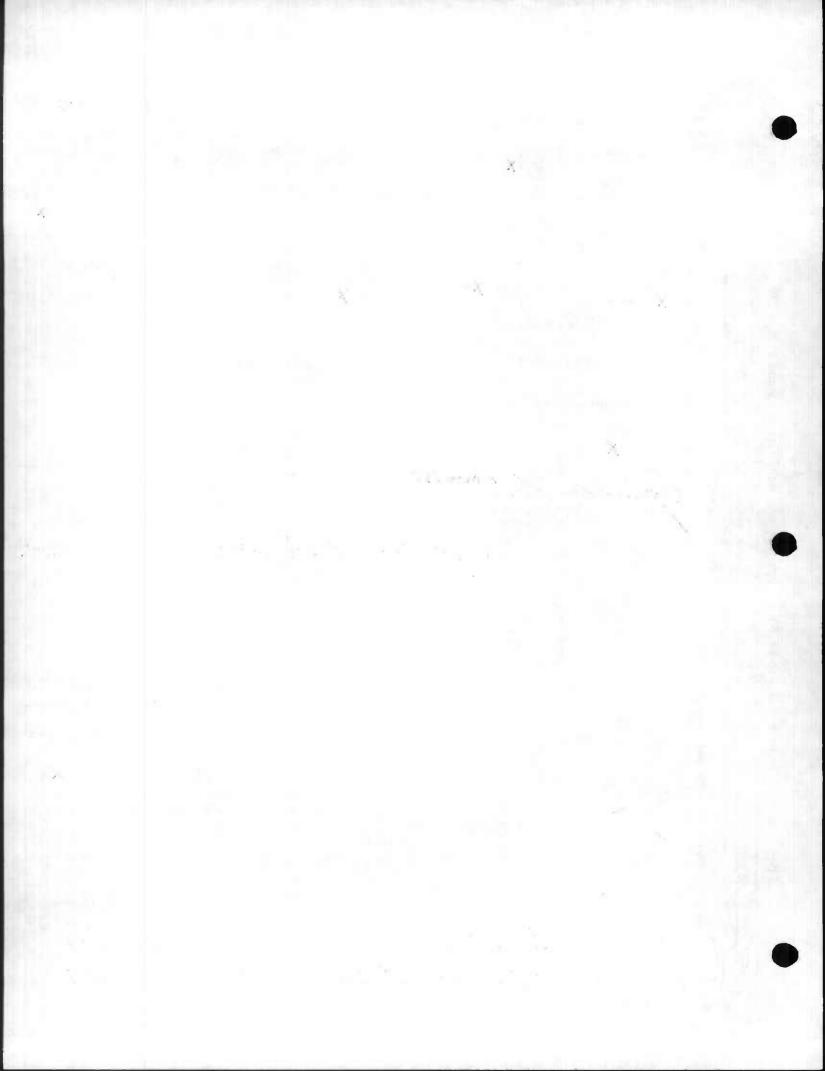
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month **Physician** Patricia Custer Jackson 6:00 March 30, 1999 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Clarksville 6121 Trotter Road If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) **Funeral** 1□ M 2 F Months Deys Hours 73 Yrs Pennsylvania Director 225-22-9241 October 20, 1925 Usuel Residence of Decedent with the Marylend 10d. Inside City Limits 10e. State 10b. County 10c. City, Town or Location . .s .:mred other than "hatural", or flems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Howard Clarksville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21029 U.S.A. 6121 Trotter Road Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Plant Physiologist 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) S.C. Custer Ada Paul 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 843 Robin Hood Hill Sherwood Forest, Maryland 21405 Ms. Pamela Woodside Niece other 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ★Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ò Department of Important: If any Injury or 04/01/99 Baltimore, MD Metro Crematory Licensee 22. Name and Address of Fecility m00535 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): 88 950 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown p 9 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? has 1X Yes 2 □ No certificate or Attanding Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury el Work? 28d. Describe how Injury occurred Certification: After 1 Natural 2 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) illed in by 4 Homicide Egithe-Funeral Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier Medical To the I 29c. License number **D** 47540 29d. Date signed [Month, Day, Year) g cause of deeth (Item 23e) (Type, Print) Caroline, Baltimore, MD Coon 7143 82. Registrer's Signeture State Registrar



Please Type of Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death March 29 738 WILLIS JACKSON City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, giva street and number) MARYLAND GENERAL HOSP 5. Sociel Security Number If Under 1 Yeer If Undar 24 Hrs. Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) Months Days 1 X M 2 F 223-12-3381 Usual Rasidanca of Decedent W. VA 12-17-18 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 826 NEWINGTON AVE 21217 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) - Amarican Indian Bleck, Whita, atc. 1 Nevar Married 2 Married 1□ Yas 2N No Spacify: Specify: 3 Widowed 4 Divorced BLACK 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 12 SANITATION WORKER BALTIMORE CO. 18. Mother's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) UNKNOWN UNKNOWN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2007 WHITTIER AVE. BALTIMORE MD. 21217 ce of Disposition (Nama of Data 20c. Location - City or Town, Stata EDWARD COATES 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ZION CEMETERY 4-2-99 BALTIMORE MD 22. Nama and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signatura of Funaya Sarvica Licensee 1300 EUTAW PLACE BALTIMORE MD. 21217 23e. Part1. Enfer the disease, or complications thet caused the death. Do not enfer the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximeta Intarval Batwean Onsat and Death Immediata Causa (Finaf disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to Immediata ceusa. Entar Undarlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or es e consequança of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings eveilable prior fo 24a. Was an autopsy performad? completion of causa of death? 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 1 Yas 2 No 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA 28b. Tima of Injury 28d. Dascribe how Injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant

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6 Could not be datarmined 28a. Placa of Injury - At homa, farm, streef, factory, office building, atc. (Specify) 3 Suicida 4 - Homicida 29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29b. Signature and file of certifi 30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

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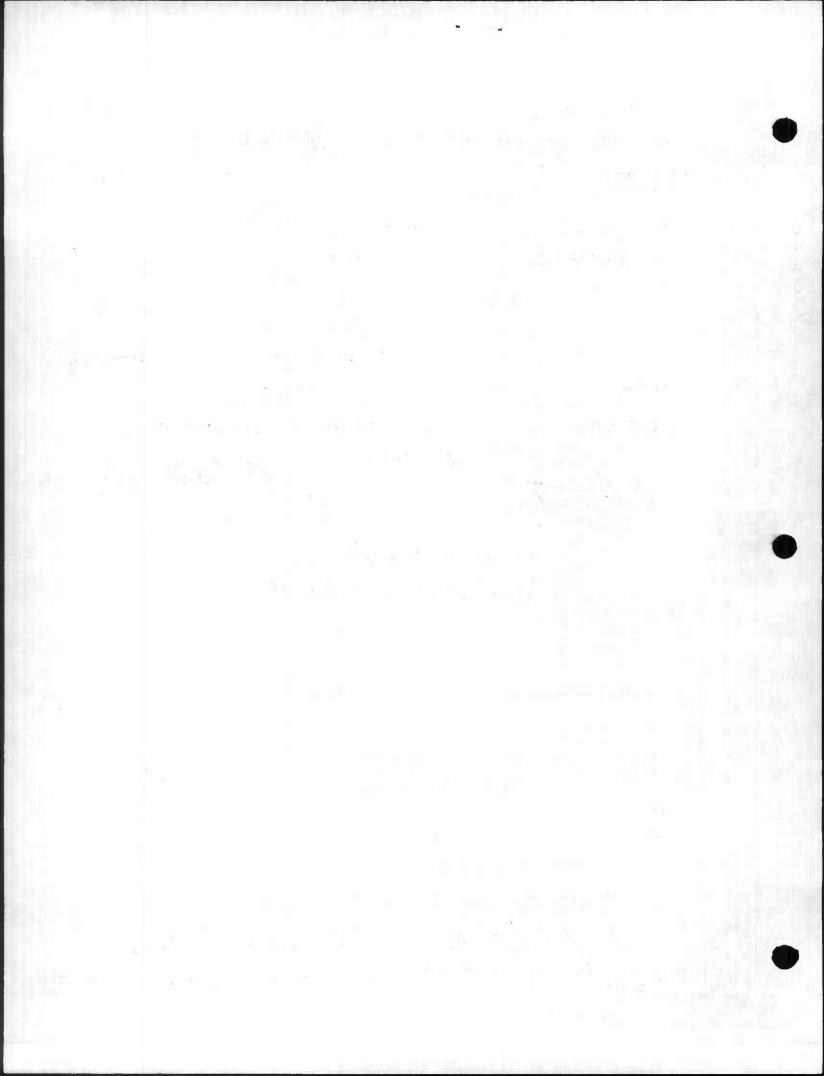
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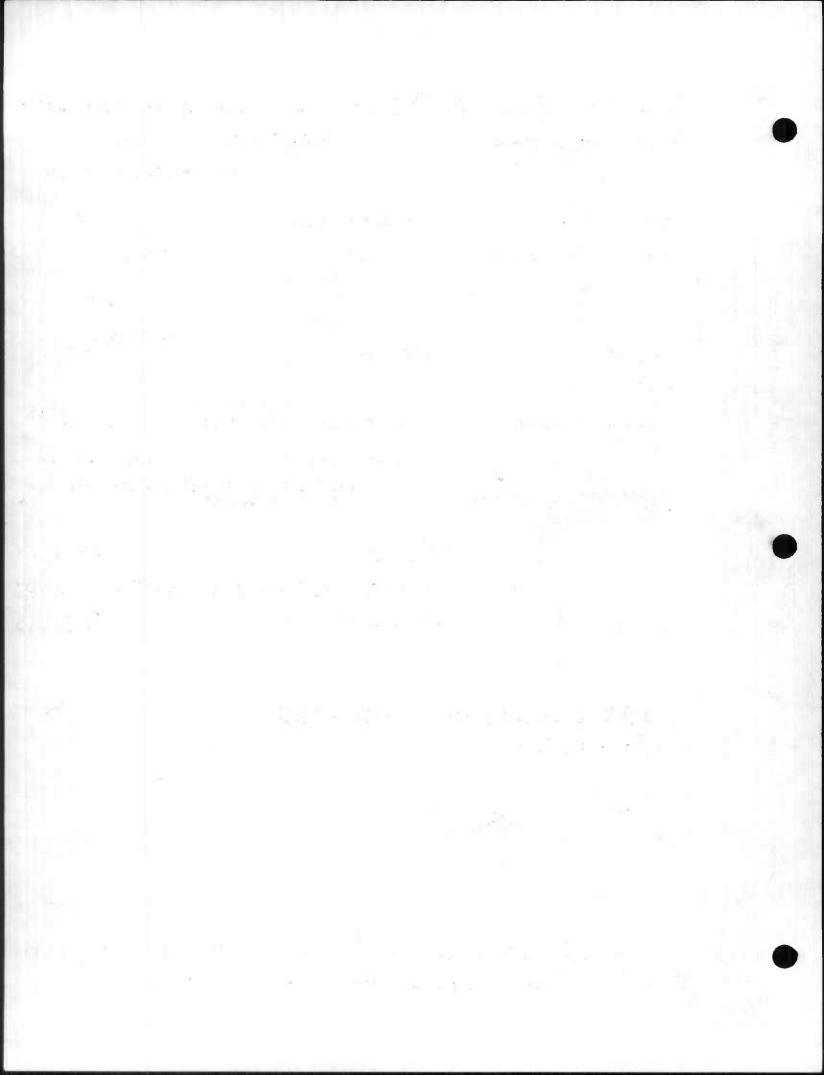
maryland General Hospital

Registrar



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	State of Maryland	d / Department of Health and M Certificate of Death	Reg. No.	10641					
Physician /Medical	1. Decedent's Name (First, Middle, Last) LILLIAN ELAINE		MARCH 29 1	3. Time of Deeth					
Examiner Funeral Director	4e Fecility Nema (If not institution, give street end number) SINAL HOSPITAL 5. Sociel Security Number 6. Sax 7. Age (In yrs. I) 1 M 20 F	(ast birthdey) A Yrs. Ab. City, Town, or Lo B AUTI M If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year)						
	Usual Residence of Decedant 10a. Steta 10b. County 10c. City	, Town or Location		10d. Inside City Limits					
e Man	MARYLAND N/A	BALTIMORE CITY		1X as 2 No					
with the Main or 28e-f s. De noticed	10e. Street end Number	10f. Zip Code		10g. Citizen of Whet Country?					
72 hours after deeth with the Maryland natural; or items 23s or 28s-f show a call Examiner must be noticed.	3111 PRESBURY STREET 11. Marital Status 1 Nevar Marriad XXMerried 12. Was Decedent Evar in U. Armed Forcas? 1 Yes 2 XNo II Yes, Give	S. 21216 S. 13. Was Decedent of Hispenic Origin? (Spe If Yas, specify Cuban, Mexicen, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Black,						
c . 3 - 5	3 Wildowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) lifa. DO NOT usa ratired)	ing BALTIM	Specify: BLACK 16b. Kind of Business/Industry BALTIMORE					
	8th grade 17. Fether's Neme (First, Middla, Last)	CUSTODIAN 18. Mother's Name	CITY S (First, Middla, Meiden Surname)						
B c d al W	WALTER TILGHMAN	unknown							
0 6 0 6	19e. Informent's Name/Ralationship (Type, Print) Bruce Jenkins/Husband	19b. Mailing Address (Straat and Number or Rura 3111 Presbury St.,	I Route Number, City or Town, Sto	ete, Zip Coda)					
of Heal	20e. Method of Disposition 1 Disturial 2 Cremetion 3 Removel from State	lace of Disposition (Neme of emetery, crematory or other place)	Dete 20c. Location - Cit	timore, Maryland 20c. Location - City or Town, State WOODLAWN, MARYLAND					
DEBLITHING PAGE Department Important: I any Injury on the page of	21. Signature of Funeral Service Licenses Livery	22. Name end Address of Fecility WILLIAM C BROW 1206 W NORTH A	N COMMUNITY F						
bhysician //Medical Examiner certificate be executed for use as the burishman and for use as the burish	Sequentielly list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or injury	PSIS res a consequence of): 545 FEM ORGAN r as a consequence of): TRORE ras a consequence of):	u FKILURI	E 24 Hours 9 DAYS					
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- 6 6 6	CARDIOMYOPATH	1, DILKTED	1 Yes 2 No 3	1 Yes 2 No 3 Probably 4 Minknown					
as been a 2 should	DEMENTIA		24a. Was en autopsy performed?	24b. Were eutopsy findings eveileble prior to completion of ceusa of death?					
The Late has page			1 ☐ Yas 2 No	1 Yas 2 No					
Physician: Tu- Physician: Tu- inis certificats rai director, ps;	25. Wes cese referred to medical examiner?	26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)							
VISION OF Attending Physics of Seator: After this of by the tuneral din iffication: To	27. Manner of Death Seturel 5 Pending (Month, Dey Year) 2 Accidant invastigation		ad. Describe how injury occurred 3d. Location (Street end Number or Rurel Route Number, City or Town, Stete)						
2 pers 2	3 ☐ Suicide 6 ☐ Could not be determined 28a. Place of Injury - At he building, etc. (Specify								
Hospi Fully Sical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my known and mennar stated.	wiedge, death occurred at the time, date end plece, tion and/or invastigation, in my opinion, death occurr	end dua to the ceuse(s) and manr red at tha tima, data and place, an	ner es stated. d dua to the ceuse(s)					
Med Med	29b. Sign at up and title of certifier	29c. License number	29d. Data signed (29d. Data signed (Month, Day, Year)					
11/	30. Name and aduress of person why completed ceusa of daath (Item	5(NGEN (125) (-C) -	THI MARCH	29, 1999					
Wh	CRAG SINGER SIN		BALTIMOR	E					
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signe	A. Sparkel	0						

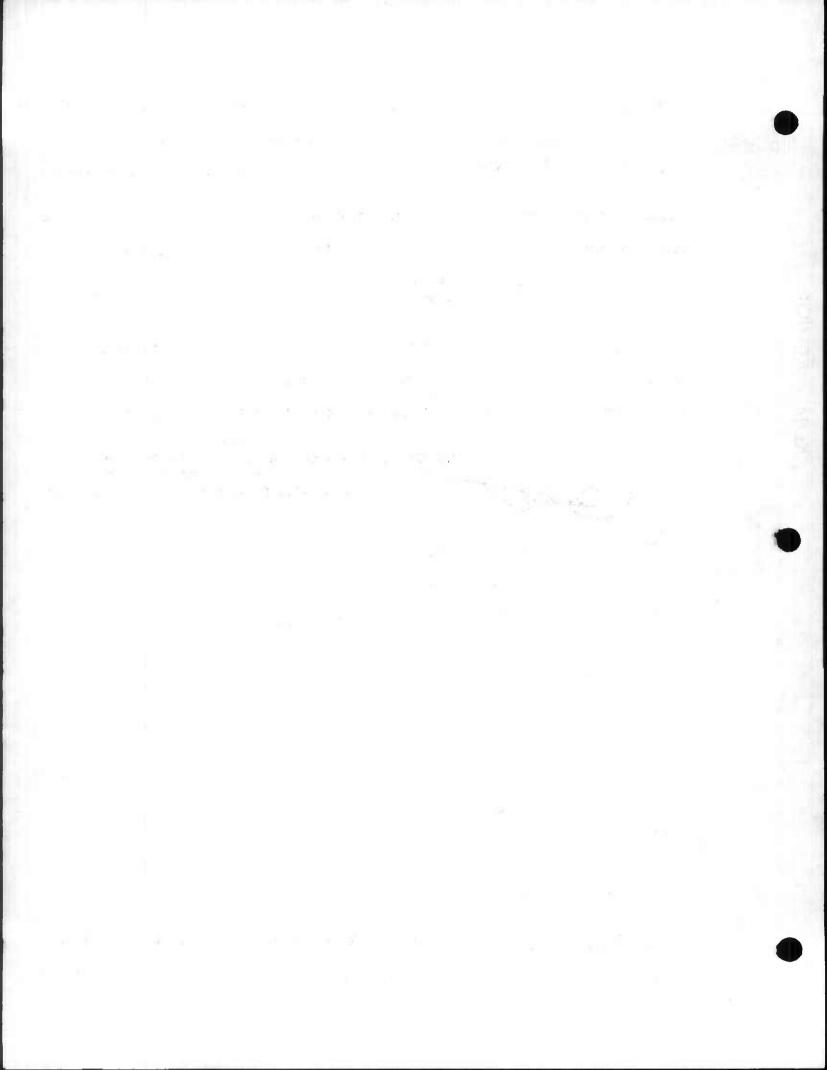


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State of Maryland / Department of Health and Mental Hygiene 10642 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** 6.20 Am FRANCIS April RICHARD KANE /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F 80 Yrs. Director 216-18-6741 OCT. 16, 1918 | Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner next be notified at Director 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8329 ELM ROAD 21108 U.S.A. items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 N Yes 2 No 193 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1937permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or I any Injury or other traumatic event, the Magical 2006. altimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced 1939 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 10 TRUCK DRIVER SHIPPING 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be THOMAS KANE ALICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) KEVIN KANE (SON) 206 EAST ROBBERSON, WILLARD, MO. 65781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4/2/99 1 ☐ Burial 2 🛭 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER LLC STEVENSVILLE, MD. 21. Signatul 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, only one cause on each line. Approximete Onset and Deeth **Physician** /Medical Immedial use (Final METASTATIE CARCINOMA diseese or condition resulting in death) Examiner Due to (or es a consequence of): Examiner VALEUM ONIA The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last physician and s the burial-tran FIBRIEL ATION Box 68760, Physician/Medical the Due to (or es a consequence of) ettending i 8 P.O. 1 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vonknown been signed l should be dat Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Be Completed 24a. Was en eutopsy performed? page 2 : 1 Yes 2 No 1 Yes 20 No certificate of Vital director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 1 Natural 5 Pending investigation 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D45149. MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) HOSPITAL DRIVE GLEN BURNIE 301 ONA BATO. 31. Dete filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2 1999

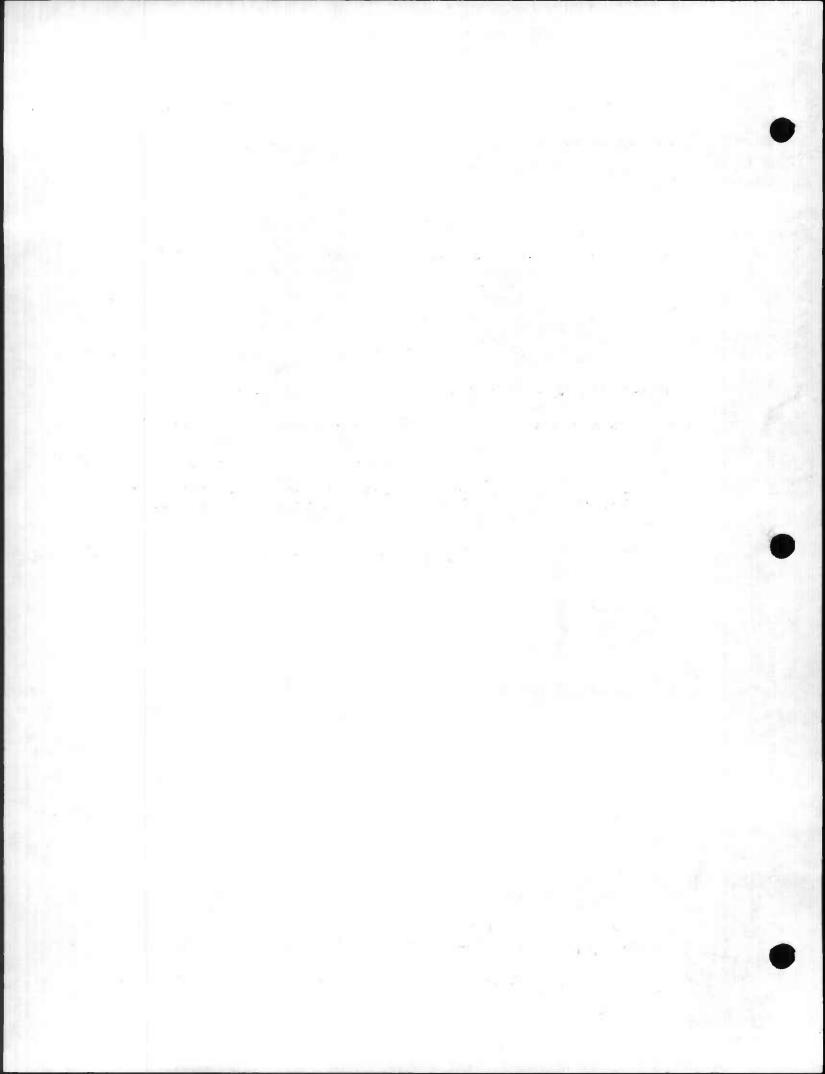
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 3. Tima of Death **Physician** 03 99 Alma L. Kennedy 31 6:20p.m. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Gilcrest Hospice Baltimore Co. Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Y 12/01/39 Birthplace (State or Foreign Country)
 AL 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours Min. 12 M 20 F 422-54-9333 59 Yrs. Director Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show ocical Examiner must be notified at 1 XYea 2 No Directo MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1622 Park Ave., Balto., MD 21217 USA Funeral deeth . 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry filed within 7 Hygiena. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) School Teacher School System 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be 2 should be f and Mental F Christopher C. Williams To Leola Farris 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 27 Balto., Health 1622 Park Ave., MD 21217 Ceophus Kennedy 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Important: If It any injury or c 1 DBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/99 Mobile, AL Gethsemane 21 Signature of Funeral Service Licensee 22. Neme end Address of Facility James A. Morton & Sons Funeral Home, Ind Con 1701 Laurens St., Balto., MD 21217 Approximata Intervel Between Onset and Death Enter the disease, or complications that cause or heart failure. List only one cause on each lin ind the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immadiata Causa (Finel diseesa or condition rasulting In death) /Medical VARIAN CANCER **Examiner** Due to (or es e consequence of): Examiner physician end the buriel-transit the death certificate be executed Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaase or injury Dua to (or es e consequenca of): Physician/Medical that Initieted events resulting in deeth) Last Due to (or es e consequence of): attending pl signed by the a 23b. Did tobacco use contribute to the cause of desth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware eutopsy findings evellable prior to complation of cause of death? 24a. Was en eutopsy performed? Completed hes a 2 cartificata he 2 No 1 Yas 2 No Attending Physician: 25. Wes case raferred to medical axaminer? Be 26. Placa of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Hompiel Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No 5 shis 28e. Dete of Injury (Month, Dey Yeer) 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Panding Investigation s after de-et Director: An-hy the fir 1 Watural 1 ☐ Yes 2 ☐ No 2 Accidant A 24 hours.
the Funeral Director of the filled in by the 6 Could not be datemined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Sulcide 28e. Pleca of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida Hospital or 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

2 Madical Examinar: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at tha time, data end plece, and due to the cause(s) end menner steted. 29a. Certifier Medical completaly (Check only one) To the To the To the I 29b. Signature apphilie of pertifie 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

1. 1. A. R. Ley G. BMC 6701 N. Charles St. Balts and 2120x 82. Registrar's Signatur 31. Date filed (Month, Day, Year) 2 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11644 ITEM: #8 PER F.H. G770 4-20-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** Hilda Lilly 24 1999 March 1:05 P.M. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore Genesis Care Center If Under 1 Year 8. Data of Birth (Month, Pay, Year) Feb. 27, 1913 Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1 M 2 F Yrs. February 27,1999 West Virginia Director 234-62-7029 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Mentland and of Heelih and Mentla Hyglene. Intel if Hen 22 I is marked other than "natural", or hems 23a or 28a-1 show any or other than man be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21234 USA Funeral 2503 Moore Ave 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. 1 Yes 2V No 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 XNo Specify: Specify: à 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 cook School System 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) 8 Daniel Johnson Cook Lou Alice Lilly 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) 2503 Moore Avenue, Baltimore, MD 21234 Joseph Lilly 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) Data 20c. Location - City or Town, Stata *Burial 2 Cremetion 3 Removal from State permit. Pege Department of important: If eny injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Tom Lilly Cemetery 3/27/99 Ghent, W. VA. 21. Signature of Funeral Service Lidensee 22. Neme end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge M.P.Inc 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth **Physician** /Medical immediate Cause (Final JEMENTIA disease or condition resulting in death) Examiner Due to (or es a consequence ot): buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es e consequence of): physicien the burie Physician/Medical Due to (or es e consequence of): 987 been signed by the s should be detached Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No MALNUTRITION à 24b. Were autopsy findings eveilable prior to Completed 24a. Wes en autopsy complation of cause of deeth? pege 2 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case refarred to finedical Be 26. Pleca of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural n 24 hours efter deeth. He Funerei Director: Aft bietely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed P.O. Box 68760, Records. Division of Vital or Attending Physicien: Hospital

certificate

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After

within 2 \$

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21215-0020

aitimore, Maryland

State Registrar

DHMH 16 Rev 6/95

Medical completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Har15 31. Date filed (Month, Day, Year) APR

300 32. Régistrar's Signeture

MP

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

E. Northern souls

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

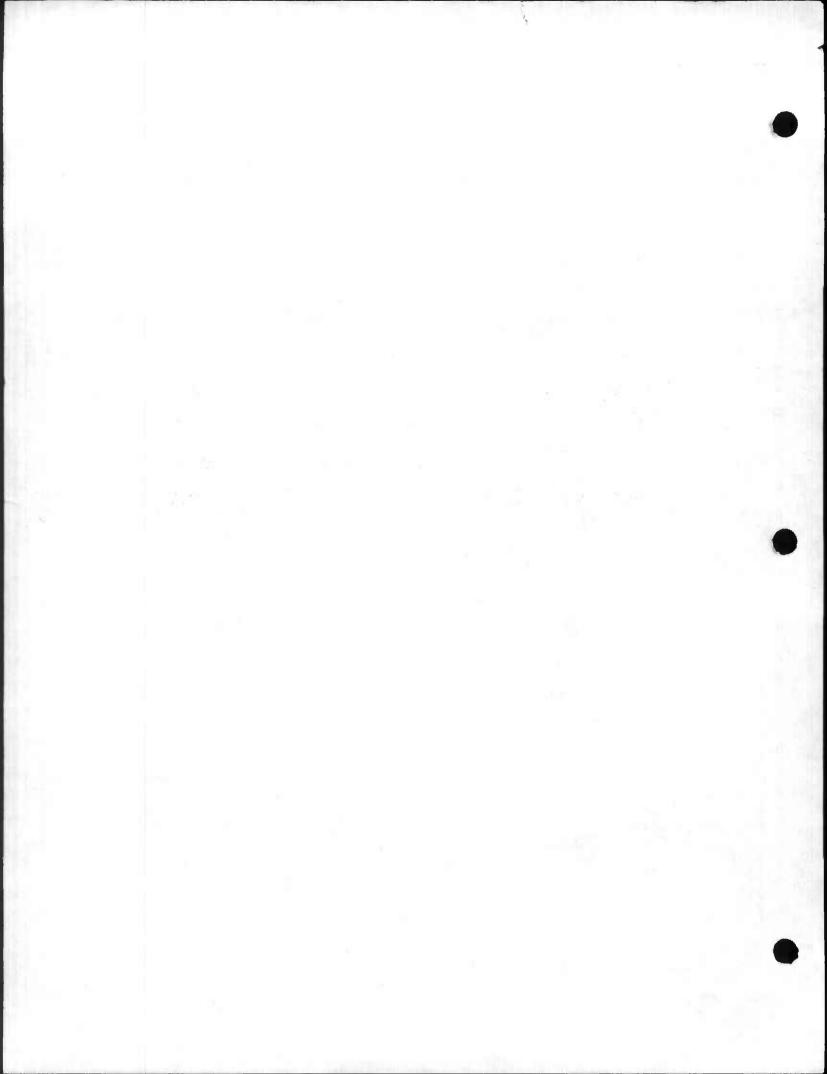
29c. License number

47945

29d. Date signed (Month, Day, Year)

Parkway Balto MD 21214

March 24 1999



State of Maryland / Department of Health and Mental Hygiene

10645

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Baltimore, Maryland 21215-0020 Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show applicative or other traumatic event, the Medical Examiner must be notified at since.		10e. Street end Number 10f. Zip Code									10g. Citizen		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 1999 8:46 PM BIRUTA LEVICKAS 30 MARCH 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth CENTER HOSPITAL BALTIMORE CITY HARBOR ALTIMORE If Under 24 Hrs. Hours Min. March 1, 1919 LITHUANIA 5. Social Security Number 7. Age (In yrs. last birthday) Months 1□M 2\ F 212-30-9580 Yrs. Usuel Residenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL CROWNSVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21032 UNITED STATES 1147 OAKVIEW DRIVE 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Merital Stetus Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) HOME MAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) (UNKNOWN) (UNKNOWN) CESNAUKAITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Raletlonship (Type, Print) 1147 OAKVIEW DR., CROWNSVILLE, MARYLAND 21032 SAULIUS LEVICKAS / SON 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition MARCH 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 31, 1999 CATONSVILLE, MARYLAND 4 Donation 5 Other (Seecily) METRO CREMATORY, INC. 21. Signature of Funeral Service Licensee RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or haart feilure. List only one cause on each line. Approximete Intervel Batw Immediete Ceuse (Final diseese or condition resulting in daath) · PROBABLE ACUTE MYOCARDIAL FNFARCTION Due to (or as a consequence of): PER TENSION Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseesa or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown TNEMIA 24a. Wes an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Be

Funeral

Director

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"natural", or

Mental 8

Department of Health Important: If Item 27

Maryland 21215-0020

altimore,

68760

Box

P.O. I

Records,

Division of Vital

or Attending

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signed t 10 Certification: death. after death.
Director: A

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ← ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6 ☐ Other (Specify) 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

1 Yes 2 No 27. Menner of Death 1 Neturel

5 Pending Invastigation 2 Accident 3 ☐ Suicide 4 Homicide

6 ☐ Could not be detarmined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated. 29c. License number 29d. Date signed (Month, Dey, Year)

amara de

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30,1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

3001 S. Hanover Street Baltimore, Mg1225 Kile . DO

31. Dete filed (Month, Dey, Year)

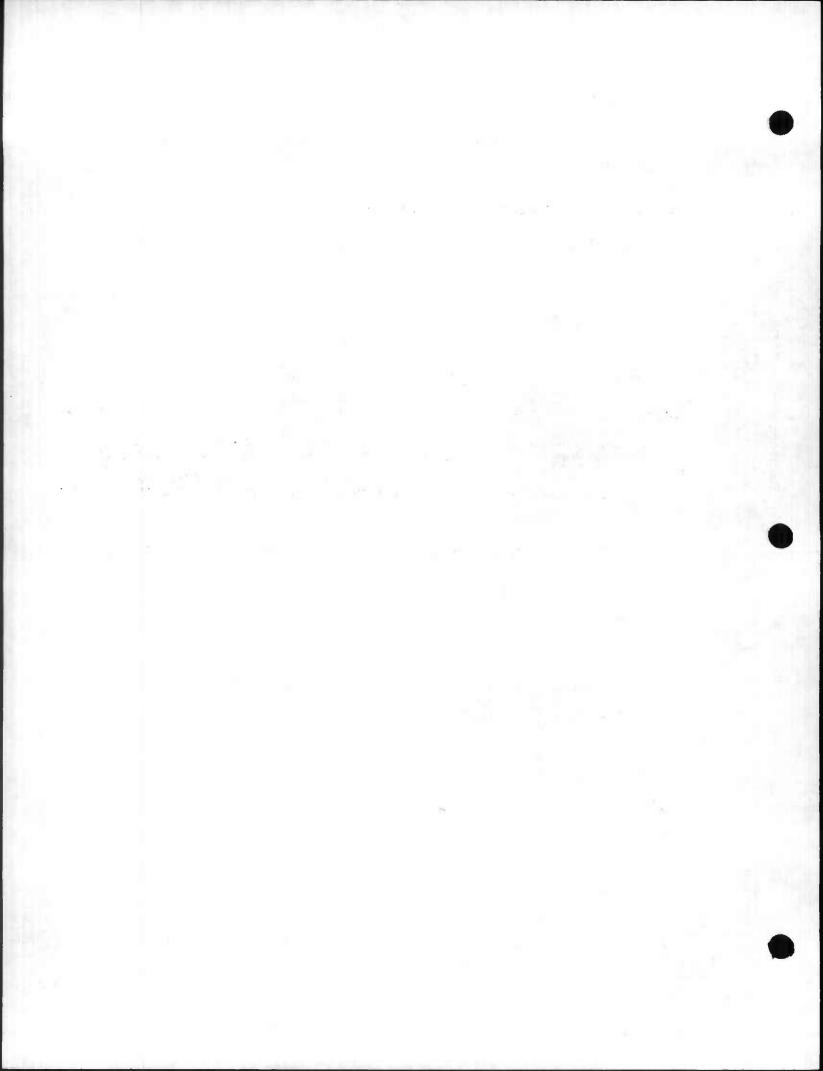
32. Registrer's Signature

APR

State Registrar

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To the To the To the I To the Medical



			411		-	rtificate		lealth a Death			Reg. No.	9	10047	
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natural, or hams 23s or 28s-f show odeal Examiner must be nothed at leted by Funeral Director	Usuel Residenca of 10a. State	of Decedent 10b. County										10d. Inside City Limits		
	Md.												1□Yes 2□No	
10e. Street and Number 10f. Zip Code 2107.						071			10g. Citizen o	log. Citizen of What Country?				
1	Armed			cedent Ever in U,S.	13.	Was Deced	/as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)					r No- 14. Race - American I Black, White, etc.		
				2 ☑No		1 Yes 2ÛÎNo Specify:						Specify: White		
	15. Decedent's Education (Specify only highest grade completed))	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occup	etion during mos	at of work	cing	16b. Kind of	Industry		
-	Elementary/Secondery (0-12) College (1-4o			(1-4or 5+)		Admin					Balti	Co. Gov.		
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Department of Health e important: If item 27 is eny injury or other training.	20e. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20b. Place of Disposition (Name of cometery, crematory or other place) St. Paul & Justin Com. April 12 10									20c. Location - City or Town, State				
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	23e. Pert1. Enter shock, or he	Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills. Md. 23e. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and post and Death of Death												
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DHMH 16 Rev 6/95

State Registrar

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32. Registrar's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MARCH 1999 WALTER 11:05 LEWIS 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, giva street and number) Baltimore enter Hospita stown Age (In yrs. last birthday) Yrs. 10XM 2□ F Days Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No more et and Number 10g. Citizen of What Country? VP. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) - American Indian Black, White, etc. 1 ☐ Naver Marriad 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced -Hmerican 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use ratired) 16b Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Wor 0 17. Fajhar's Nama (First, Middle, Last) (wife) 19b. Mailing Addrass (Street end Number of 3655 Forest RWIS 20b. Place of Disposition (Neme of cometery, crametory or other place) 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) butu of Funaral Service Licansee 22. Name and Addrass of Facility North e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, List only ona causa on each lina. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy performed? aulagin 2 0 No 1 Yes 2 No 26. Placa of Death (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Lanpatient 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Yaar) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 1 ☐ Yes 2 ☐ No

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Ne Hospital or Attanding Pl n 24 hours efter death.

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Ram 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Modical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter C Department of Healin and Mental Hygiene. Important: If flam 27 is marked other than "natural", or fer any injury or other traumatic event, the Medical Examinas

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Physician/Medical þ Completed Be 2 Certification:

25. Was cese referred to medical examiner? 1 Yes

27. Manner of Death

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

5 Panding Investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To tha bast of my knowledga, daath occurred at the tima, date and place, and dua to tha causa(s) and mannar as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title/of o

29c. Licensa number

29d. Date signed (Month, Day, Year) Mascl

30. Name and address of paragraph complehed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) APR 02

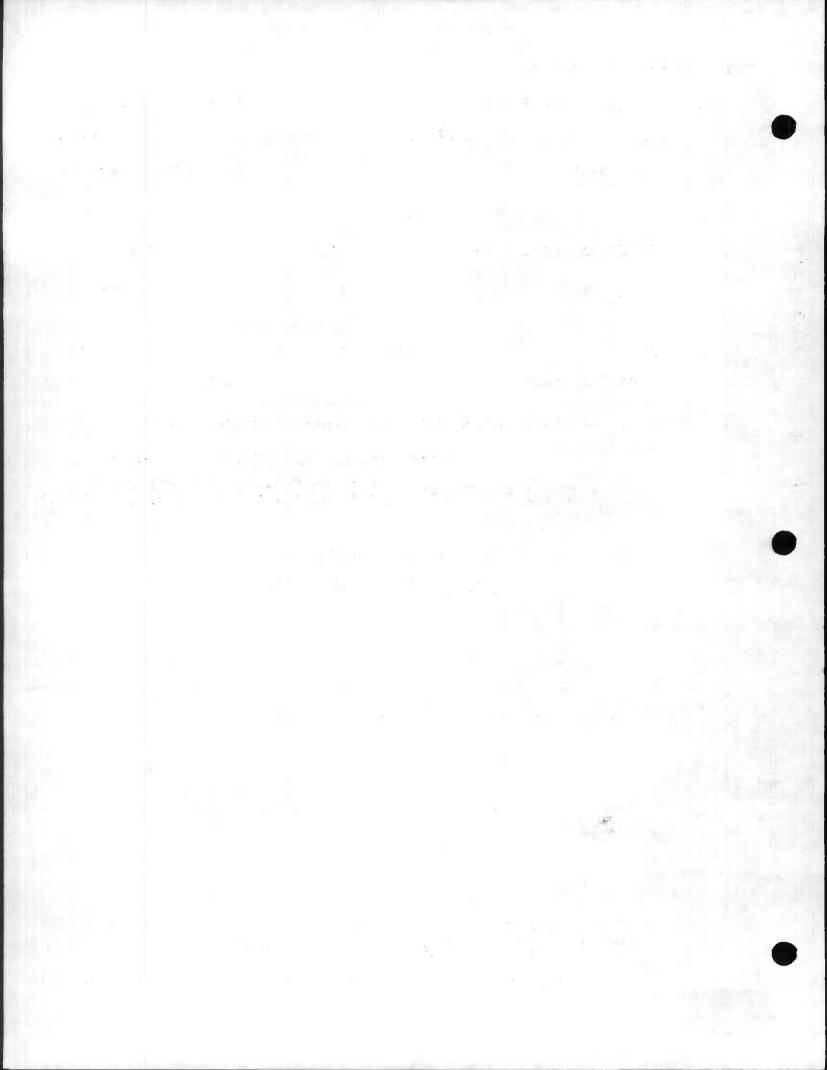
32. Registrar's Signature

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DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Vear McELROY 5:00 P.M. MARTE ALICE MARCH 29, 1999 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death LANSDOWNE BALTIMORE 3223 TARTARIAN COURT If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) SEPT. 14, 1934 MARYLAND 5. Social Security Number 7. Age (In vrs. last birthdev) 9. Birthplace (State or Foreign Days Hours Months 219-28-3416 64 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MARYLAND BALTIMORE LANSDOWNE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3223 TARTARIAN COURT 21227 II.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Stetus 14. Race - American Indien. Bleck, White, etc. 1 □ Nevar Married 2 □ Married Specify:WHITE 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) Elementary/Secondary (0-12) College (1-4or 5+) BAR OWNER (UNKNOWN) 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) COOK GERTRIDE **JOHNSON** MAY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR CUMMINGS (GRANDSON) 3001 FREEWAY, BALTIMORE, MARYLAND 21227 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Ramoval from Steta 4 □ Donetion 5 □ Other (Specify) IILL CEMETERY 4/2/99 BROOKLYN PARK, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., CEDAR HILL CEMETERY 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 and or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest A Dua to (or es a consequenca of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Examine

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Pages 1

Department of Health a Important: If Item 27 is any Injury or other tra

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Baltimore, Maryland 21215-0020

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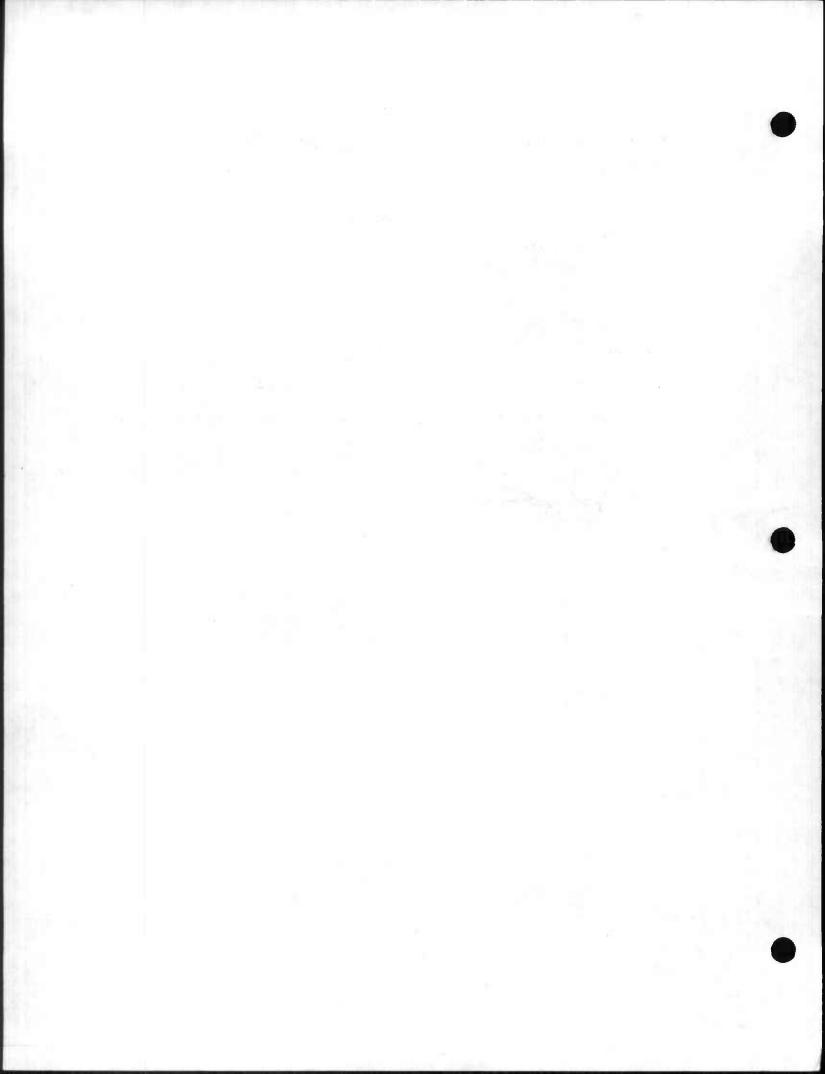
physician and the burial-transit 68760 Box signed by the a P.O. Records, page 2

of Vital Hospital or Attending Physician: Division within 24 hours a To the Funeral D completely filled

Registrar DHMH 16 Rev 6/95

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Menner-of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) end menner es stated.

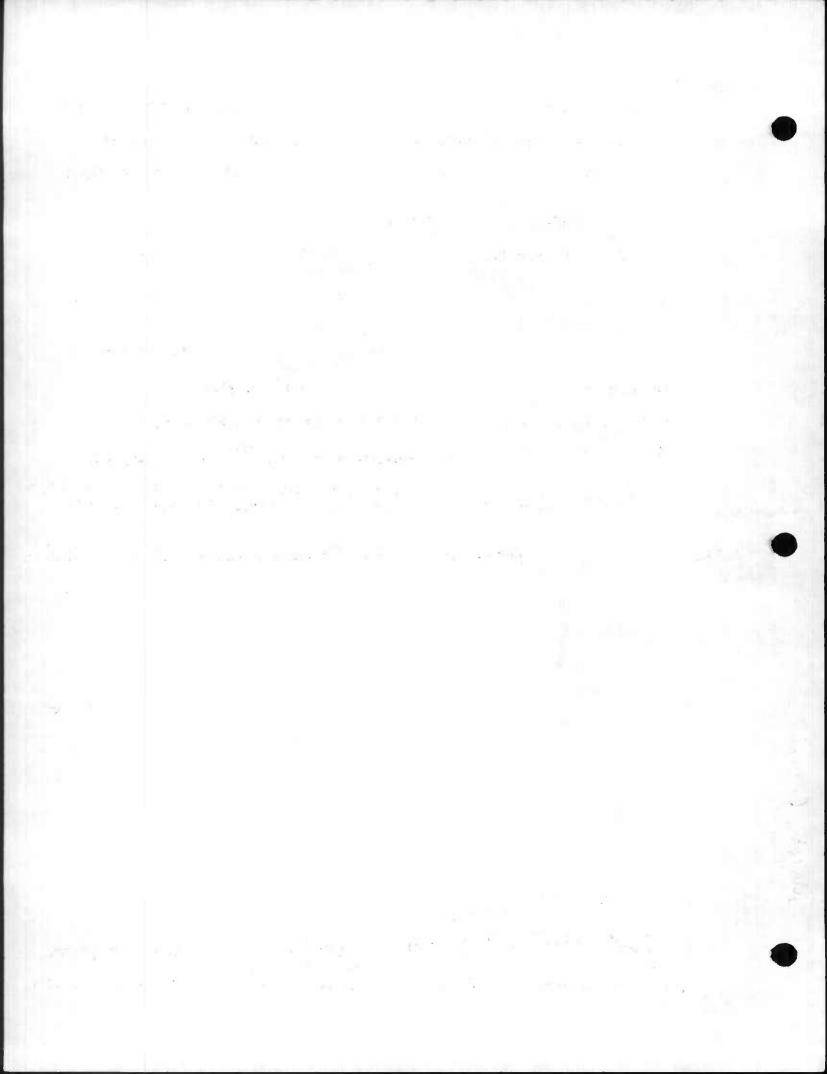
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) merce. ino buerne 31. Data filed (Month, Dey, Year) 32. Registrar's Signature per 2 1999



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State of Maryland / Department of Health and Mental Hygiene Q

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Examin	ner	ST AGNES HEALTH CARE 900 CATON AVE BALTIMON								-			
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Is marked other traumatic event, th	other traum	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mail	ling Address (Stre					, State, Zij	Code)	
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Baltimore, permit. Pages 1 ar Department of Hea Important: If Item 2 any Injury or other		21. Signature - Funeral Service Ucenye 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP,											
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ertifica ector, p	Be	25. Was cese raferred to med examiner?						Placa of Deat	th (Check only	one)			
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er th		27. Manner of Death	28a. Date of	of Injury th, Day Year)	28b. Time Injury	of 28c. Ir	njury at Nork?		28d. Describe	how Injury occu	rred		
e fune	atte	1 Natural 5 Per	stigation	, our roar,	injury		Yes :	2 □ No					
Director: A	flo	3 ☐ Suicide 6 ☐ Cou	lid not be 28e. Place	of Injury - At h	ome, farm, s	treet, factory, office	Ce		28f. Location (Street and Number or Rural Route Number				
2.5	Certification:	4 Homicida	buildir	ng, atc. (Spacia	y)				City or T	own, State)			
completaly filled	edical C	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.											
o the	M	29b. Signature and title of cert				29c. Lice	ense numt	ber		29d. Date sign	ed (Month	, Day, Year)	
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		X	The state of the s	1310		D	518	835		Mare	h 28	21220	
		30. Name and address of pers	on who complated ceus	a of death (Itar	n 23a) (Type	Print) Sour	of Ac	nes }	tealtho	are		1	
		Michael S	lverman.	MD	C	100 CA	TON	" AVE	WE	Balt	more	21220	
Sta	ate	31. Date filed (Month, Day, Ya		agistrar's Signa	ture 1	6 9	.7	,					
Registr		APR	2 1999	المعادم أيرا	1	1. 1000	uls						
		CI II	~ 1000	7									



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #28C.28D PER MD G770 4-2-99 WR. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death March 24, 1999 Year **Physician** Franklin Thomas Miller 2:50 PM/Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Joseph Richey House Baltimore N/Aif Undar 1 Year 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Min 1₩ 2□ F Months Days Hours Yrs. 57 Director AUG 26, 1941 217-78-7195 Maryland Usual Rasidenca of Dacadan 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 Yas 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 1812 W. Pratt Street 21223 USA Funeral Was Dacedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ▼No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bar Bartender 18. Mothar's Nama (First, Middle, Malden Sumama) 17. Fathar's Nama (First, Middla, Last) should be Franklin Thomas Miller Helen Elizabeth Landheart 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 Department of Health en Important: If item 27 is m any injury or other MD 21054 Viola M. Kuser/Sister 2114 Autumn Haze Court Gambrills, MD 20c. Location · City or Town, State 20b. Plece of Disposition (Nama of camatary, crametory or other placa) 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 3/26/99 Baltimore, MD 22. Name and Addrass of Fedility Cremation Society of MD, Inc. 21. Signature of Punaral Sarvice Licansi Column A. 299 Frederick Road Baltimore, MD 21228 Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical LUNG CANCER WITH LIVER AND BONE HETASIASES **Examiner** Dua to (or as a consequence of): Examiner ician and buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical the ! Dua to (or as a consequence of): 88 esn 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) HospicE Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Vas 20 No Certification: To this 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Daath 28b. Time of 28c. Injury at Work? Netural 5 Panding Hoshos al or Attending s after death. 1 Yas 2 No invastigation 2 Accident 6 Could not ba datarmined 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 4 ☐ Homicida To the Hospital of within 24 hours a To the Funeral D 29a. Cartifiar 🗹 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar es steted. Medical

State Registrar 31. Deta filed (Month, Day, Year)

JOHN B MACGIBBON

(Check only one)

32. Ragistrar's Signatura

of person who completed cause of death (Item 23a) (Type, Print)

MD

101 WREAD ST SUITE 719 BALTMORE MD 21201

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number

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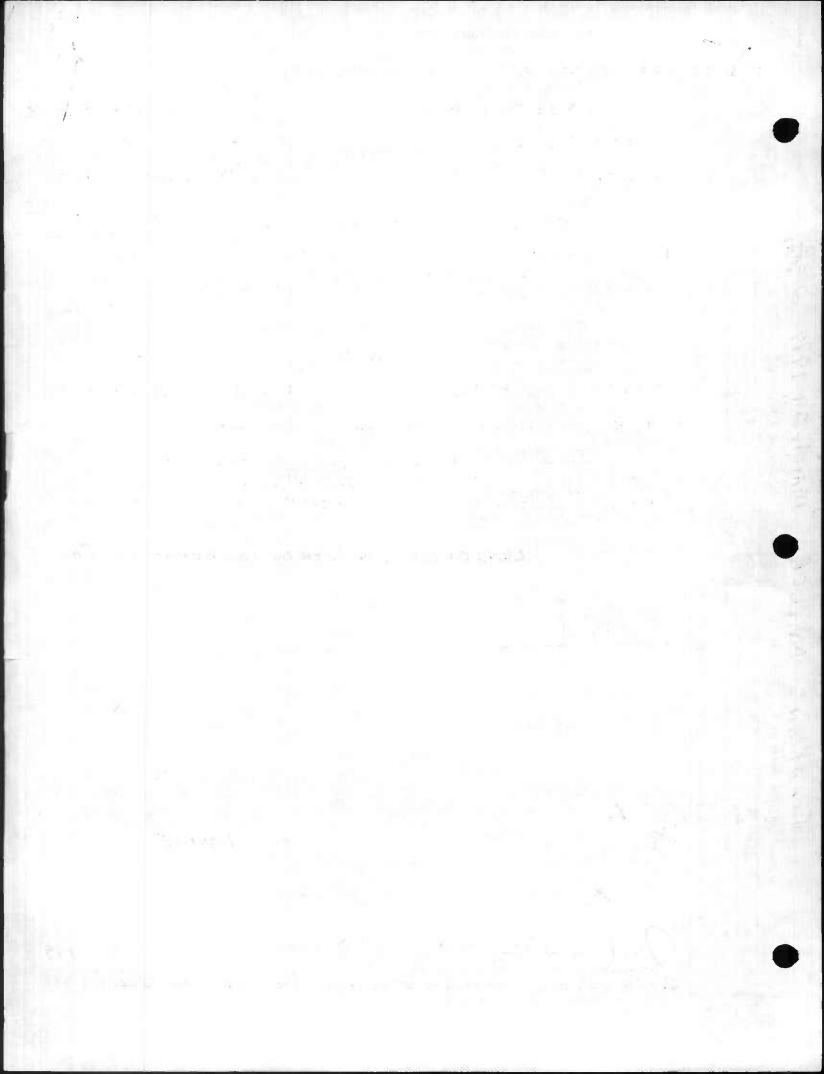
29d. Data signed (Month, Day, Year)

TARCH 25 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey PATRICK A. O'DOHERTY MARCH 27, 10:45AM 1999 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 104 SOUTH PARADISE AVENUE CATONSVILLE BALTIMORE If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dev. Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Deys Min XDM 2□F Months Hours Yrs. 73 OCT 3 1925 MARYLAND 219-18-2012 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 104 SOUTH PARADISE AVENUE 21228 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 Never Married 2 N Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ATTORNEY SELF EMPLOYED 5+ 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) EDWIN A. O'DOHERTY PATRICIA K. MURPHY 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROSE O'DOHERTY, WIFE 104 SOUTH PARADISE AVE., CATONSVILLE, MD 21228 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE NATIONAL 3/31/99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. la 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Prostate Immediate Ceuse (Final disease or condition resulting in death) Cancer Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributa to the causa of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 010 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28h. Time of 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Natural 5 Pending 1 Yes 2 No € Accident Investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Ruret Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier 29b. Signeture and title of ceptifier 29c. License number 29d. Date signed (Month, Dev. Year,

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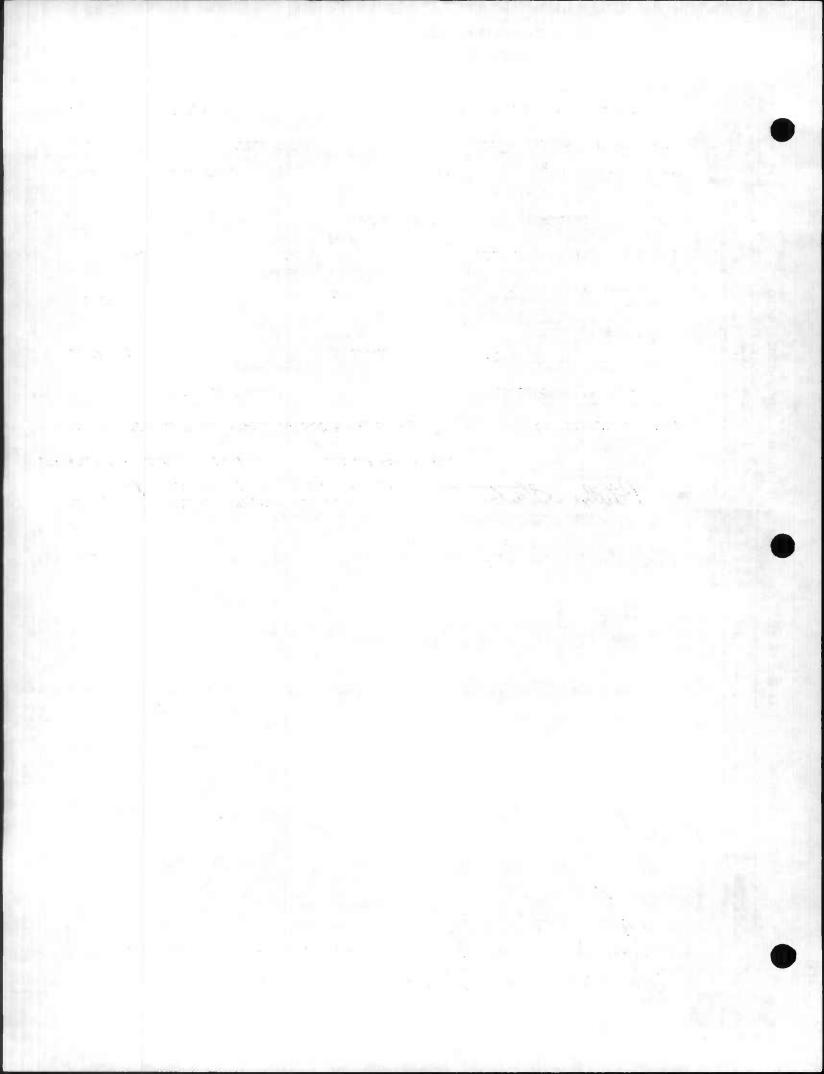
31. Date filed (Month, Dey, Year) 2 1999

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32. Registrer's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

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32. Registrar's Signature

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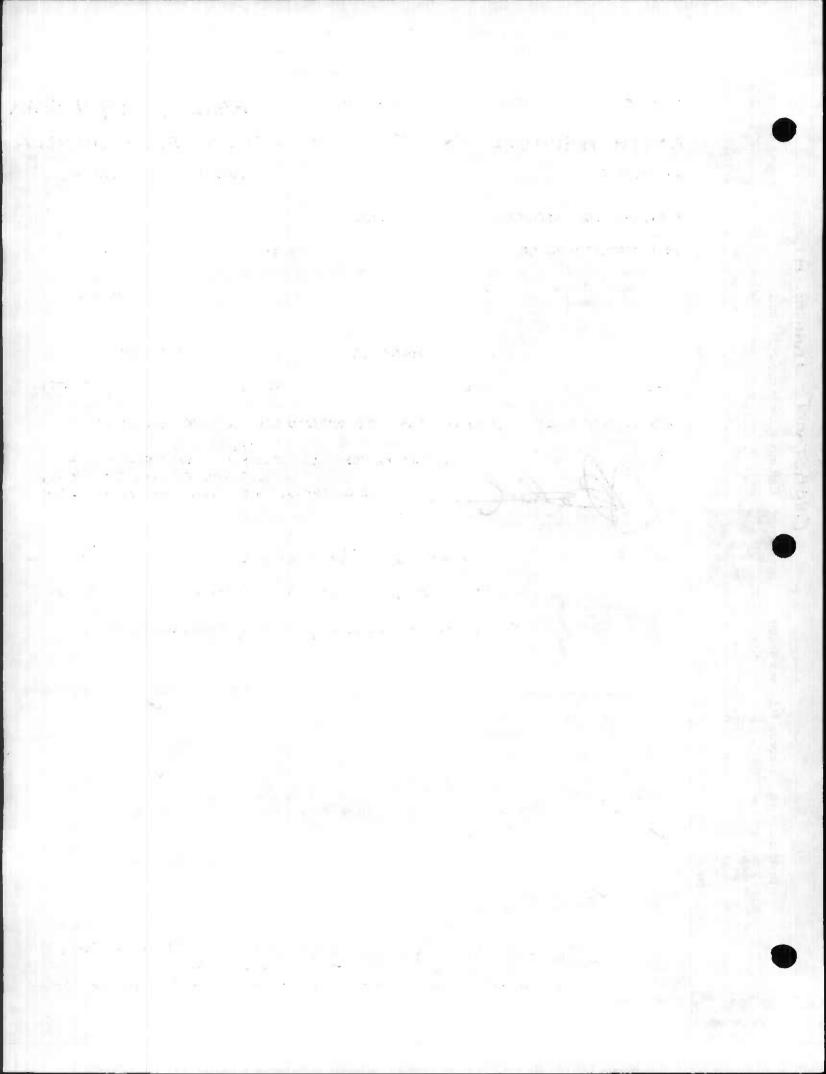
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State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month GERTRUDE L. PTOTTE APRIL 1 , 1999 1:30AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death CHESAPEAKE HOSPICE LINTHICUM ANNE ARUNDEL If Under 1 Year 5 Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1□ M 280 F Months 030-07-2065 86 JUL 26 1912 MA Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1335 E. PATAPSCO AVENUE 21225 USA 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Pace - American Indien Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3℃ Widowed 4 Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 6 OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) EUGENE DuPONT PRUDENCE BEDARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) THEODORE D. PIOTTE, SON 1335 E. PATAPSCO AVENUE, BALTIMORE, MD 21225 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) WILDWOOD CEMETERY 4/6/99 WILMINGTON, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Willes STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. ach 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest,

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Approximately 100 and 121228 and 12228 and Approximate Interval Between Onset end Death Immediate Cause (Final a Months disease or condition resulting in death) MULTI INFARCT EMENTID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown ELLPTUC BREAST 24a. Was en eutopsy performed? 24b. Were eutopsy tindings evailable prior to completion of cause of death? CANCE IZ OLON 1 Yes 2 LA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury el Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of eyemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s)

Records, P.O. Division of Vital Hospital or Attanding Physician: To the

Box 68760.

State Registrar

Physician

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Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)

29b. Signature and title of gertifier

32. Registrar's Signature

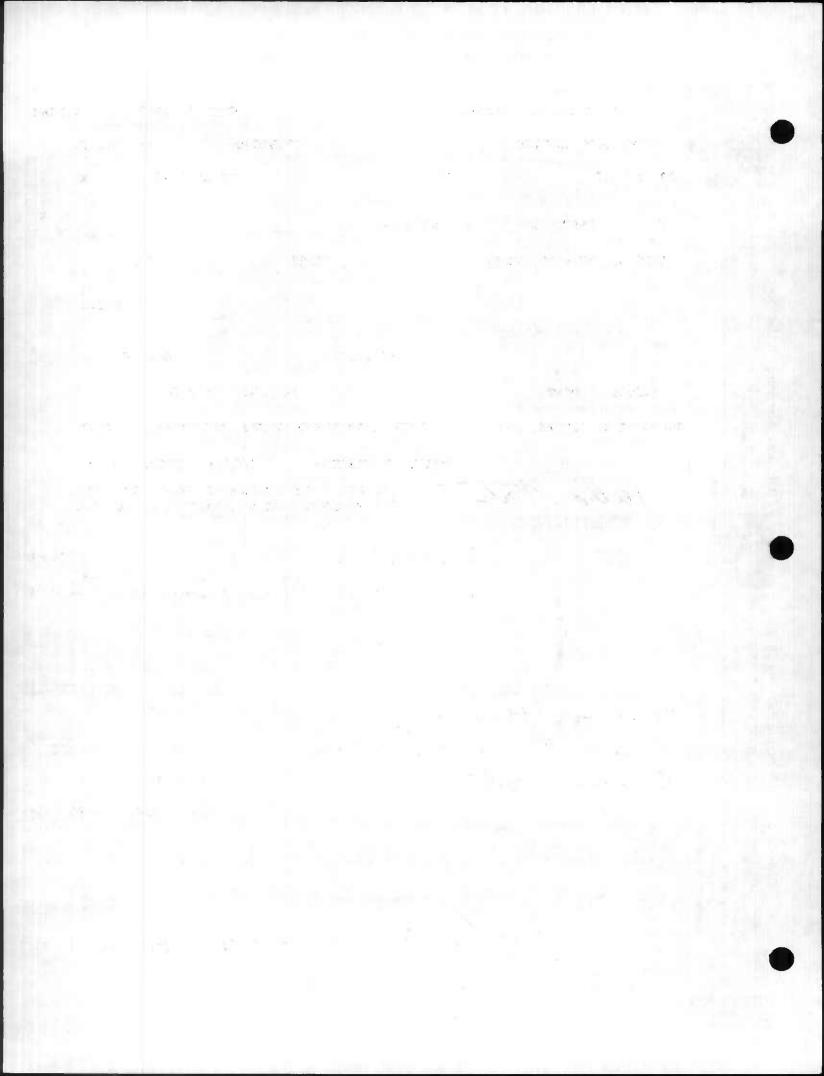
30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

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29c. License number

29d. Date signed (Month, Dey, Year) SRIL

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ALBERT MARCH /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Baltimore If Under 24 Hrs. 8 University of Maryland Hospital 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1XM 2□ F Hours Min 62 Yrs. 1937 Maryland Director 215-36-8346 Usual Residence of Deceden with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8401 Jandy Avenue 20723 USA filed within 72 hours efter death v Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Bace - American Indian 11. Marifal Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Copparament of Health and Mentel Hygien Important. If item 27 is marked other that any injury or other traumatic event, it is once. ACTS Flight Manager NASA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Willis Phebus Janice Meredith Webster 19e, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn Martin/Step-Daughter 7780 Blueberry Lane, Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Garden 4/3/99 Bel Air. Maryland 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Lawrel, MD 20707

Approximately one ceuse on each line.

Approximately one ceuse on each line. Part Enter the disease Approximate Intervel Between Onset end Death **Physician** · MYELOPROLIFERATIVE DISORDER /Medical immediate Cause (Finel disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Physician/Medical Examiner attending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Autoimmune HEmolytic Anemia 1 Yes 2 No 3 Probably Unknown À 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was en autopsy ThrombocytopENIA 1 Yes 2 No 1 ☐ Yes 2 No this certificate To the Hospital or Attending Physicien: Within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. Be 25. Was cese referred to medicei exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No Lo 27. Manner of Death 1 Z3Netural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

State Registrar

31. Date filed (Month, Day, Year)

MARK KIM, MD

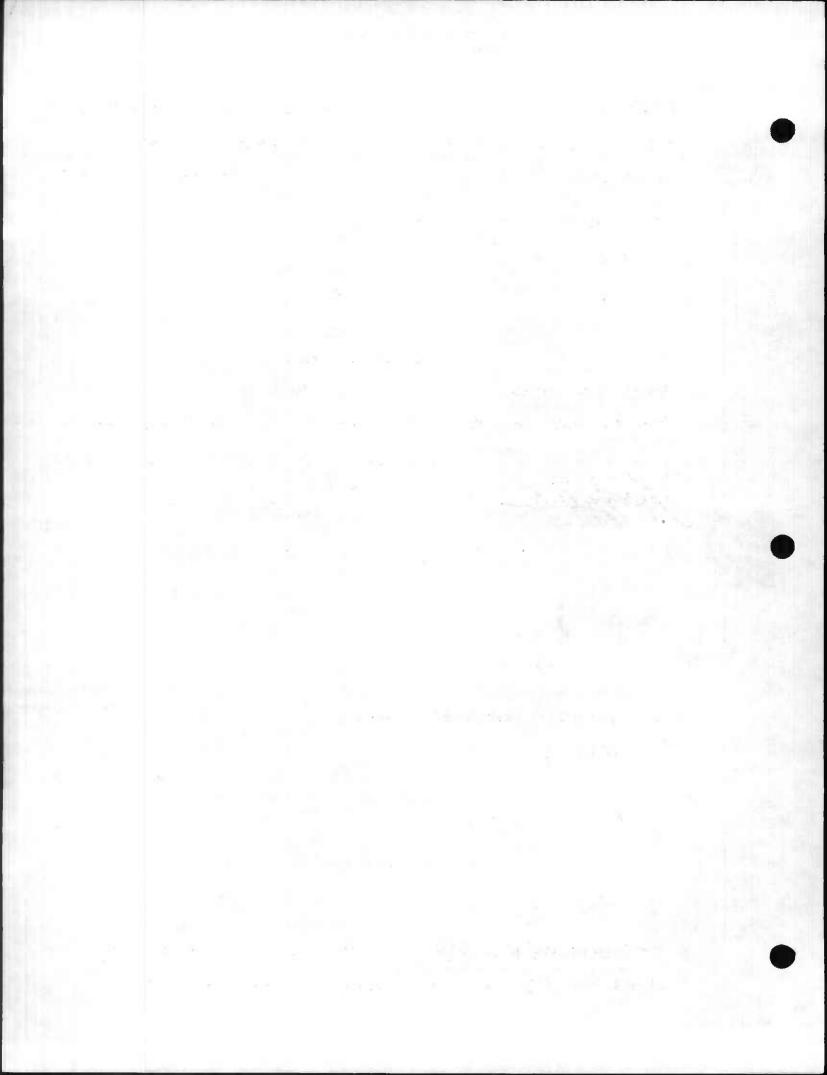


marking Kim, MD 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

22 South GREENE St. BALLO MD 2120

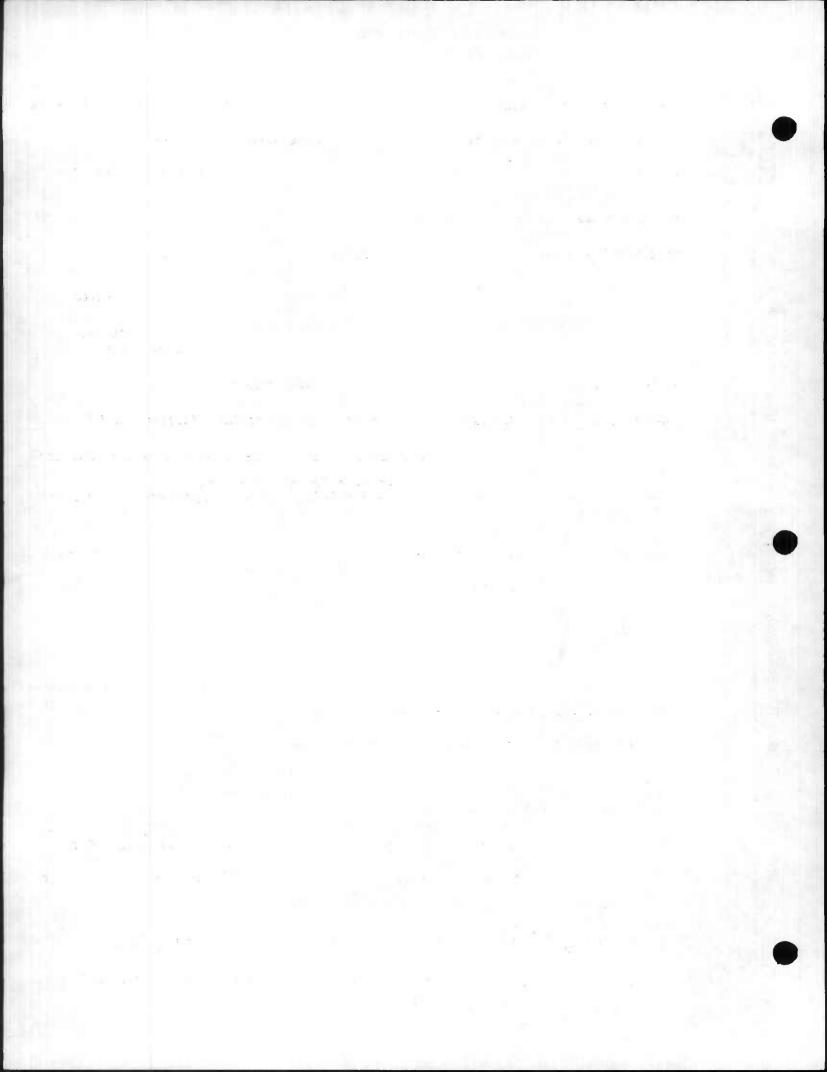
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ath with the Marylar 23s or 28e-f show and be notified at rail Director	1310 Barclay Road		U.S.A.									
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il Hygier other th	12 17. Fether's Neme (First, Middle, Last)	12 Secretary						Government				
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E = N L	Robert J. Phillip					Barclay,						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20e. Method of Disposition		. Plece of Dis	position (Neme of remetory or other pl		Dete						
permit. Pages 1 at Department of Hea Important: If Item: any Injury or othe 2008.	1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify	ille,	le, Maryland									
	22. Name end Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781											
	23a. Part1. Enter the disease, or comp	olications that mused the de	eath. Do not e				_	rre,	Approximete			
Physician Mealtul	23a. Plant. Inter the disease, or complications that shaped the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on a set line. Approximate Interval Between Onset and Death											
	Immediate Ceuse (Finel disease or condition		30 Minutes									
Examiner	resulting in deeth)		JO HILHGEED									
P # P		Hip Fract	ure					1:	10 Days			
ate be executed sysician and he burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, Disease or injury c.											
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g phys as the	that initiated events resulting in deeth) Lest Due to (or es e consequenca of):											
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res that the designed by the a be detached for by Physic	Arteriosclerotic	10	1 ☐ Yee 2 No 3 ☐ Probably 4									
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has b							of deeth?					
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Physician: The certificate ral director, page Co.: To Be Co.:		Hospital: 1 ☐ Inpatient 2	□ EB/Outpat	ient 3 DOA	thor:	of Deeth <i>(Check only</i> sing Home 5 ☐ Re		ther (Snec	nihe)			
Physic prthis c eral dire		28a. Dete of Injury	28b. Time	of 28c. Inj		28d. Describe	how injury occu	urred				
Attending or death. octor: After fune by the fune	1 ☐ Neturel 5 ☐ Pending investigation	(Month, Dev Yeer)	2:00	A4 4 7	ork? ⊒Yes 2∭N		Subject was sitt Then she slipped					
tal or Attending P is after death. at Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined				9	28f. Location	28f. Location (Street end Number or Rural Rout City or Town, Stete)					
Se din Co								1310 Barclay Road, Barclay, M				
To the Hospital or Attention 24 hours after of the Toneral Direct contribution in the Medical Certification of the Toneral Certifica		vsician: To the best of my liner: On the basis of exam										
Wed A									n, Day, Year)			
F # 4/8	() ()		3/201	00	,							
11	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)											
10	Patrick J. Shanah				uite 2.	Chestert	own, Ma	rylan	d 21620			
State	31. Date filed (Month, Dey, Yeer)	Registrer's SI	mature	3			-	-				
Registrar	APR 0 2 1999	poure	19.	Sports	/							
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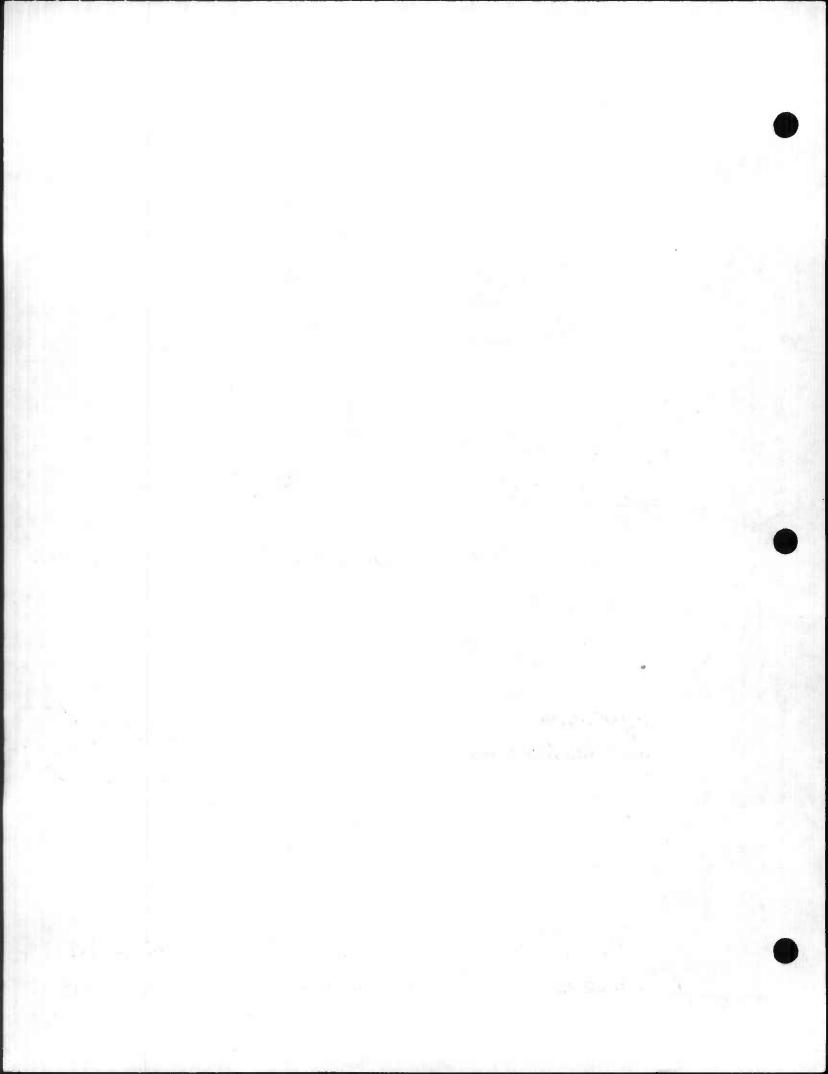


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Physician Newman B. Rowe 1999 April 11:00A.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6617 Perch Way Elkridge Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 1MM 20 F Yrs. Director 227 18 8161 73 Feb. 6, 1926 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hydrens. Important: If Item 27 is marked other than "natural", or Nama 23s or 28s-4 show eny injury or other treumatic avent, the Medical Examinar must be notified at Pages. 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Elkridge 1 ☐ Yes 2 X No Howard Director 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6617 Perch Way 21075 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black White atc 1 ☐ Yes 2 🖄 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 No Specify. Specify: þ black 3 ☑ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) chemist Pensi Cola altimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 8 Louis Rowe Eva Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Cecil Glover (daughter) 8328 Granville Rd., Jessup, MD., 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 4/7/99 Washington, D.C. 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Gary L. Kaufman Funeral Home @Meadowridge 7250 Washington Blvd.Elkridge,MD 21075 23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical accident Cerebrovascular week Examine Due to (or as a consequence of): Physician/Medical Examiner physicien end s the burial-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequence of) signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Hypertension Records. þ 24b. Wara autopsy tindings available prior to completion of causa of death? Hypercholesterolemia Completed 24a. Was an autopsy performed? pege 2 1 Yas 20 No 1 Yes 2 No certificate of Vital or Attending Physicien: Attar this certific funaral director, 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Presidence 6 Other (Specify) 1 Yes 20 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Division 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of p d cause of death (Item 23a) (Type, Print) L. Poblete Paturent Parkway, Columbia MD 21044 Little 11055 31. Data filed (Month, Day, Year) 32. Registrar's Signature. State Registrar APR 2 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per AB FilmG769 3-25-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1999^{Year} **Physician** March 15, 9:15 PM naebora /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 208 UI gomeru If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, 9. Birthplece (State or Fore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 19-48-1100 1 M 2 F Yrs Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nem 27 is marked other than "naturel", or items 23e or 28a-1 ehow other traumatic event, the Medical Examiner must be notilised at 1 ☐ Yes 2 No Director 30 omer 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 OL 20 Funeral 2 should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if them 21 is marked other than "naturel", or flems any Injury or other traumatic event Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: p nit 38 Widowed 4 □ Divorced Completed 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) omen Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OF Maria 1050 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Plece of Disposition (Name of cametery, cremetory or other place) arbaras wante Date 20a. Method of Disposition 20c. Location City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation 21. Signeture of Fuceral Ronal d Service Licenses S. Wade State Anatomy Board, Difector 655 W. Baltimore Street Baltimore, Maryland 21201 234 Pm11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and k, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last and Due to (or es a consequence of) certificate be execu Division of Vital Records, P.O. Box 68760, attending physician mar Physician/Medical Due to (or as a consequence of) eavs USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown by 8 24b. Were eutopsy tindings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? has page 2 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Dey Year) funeral 28d Describe how Injury occurred 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? To the Hospital or Attanding P within 24 hours after death.
To the Funeral Director: After 5 Pending investigation Natural 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) and menner stated.

death (Item 23a) (Type, Print)

1993^{32. Regis}

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

edical

2

29a. Certifier

29b. Signa

(Check only one)

ame and address



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Isaiah Luke Ritterspach MARCH 22 2:50 pm 1999 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth ALTIMOLE CITY If Under 24 Hrs. 8. Date of Birth HOS PITAL s. last birthday) If Under JUHNS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Months Hours 1 M 2 F Deys March 22,1999 Maryland Unknown Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel MD Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 111 First Avenue, SE 21061 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18 Mother's Name (First Middle Meiden Sumame) 17. Father's Neme (First, Middle, Last) Kimberly Lawson Steven Alan Ritterspach, Sr. 19e. Informent's Neme/Reletionship (Type, Print) (Father) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven A. Ritterspach, Sr. 111 First Avenue, SE, Glen Burnie, MD 21061 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Steta 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from Stata Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 21. Signatury of Fune N Service Licenses 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease of a mplicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) 1 hours fespiratory failure Respiratory distress Syndrone Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Extreme Prematur Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Beeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

physicien end s the buriel-transit The lew requires that the death certificets be executed 88 attending for usa as signed by the a been signature s certificata has b director, pege 2 s al or Attending Physician: T s after death.

N Director: After this certificat of in by the funeral director, pu

Physician

/Medical

Examiner

Funeral

Director

or 28a-f shows

Pages 1 and 2 should be filed within 72 hours efter death with nent of Health and Mental Hygiana.

Int: If item 27 is marked other than "natural", or items 23a or rany or other traumatic avent, its Model Examination in the second page.

permit. Pages Depertment of Important: If it any Injury or o

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

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29a. Certifiar

(Check only one)

Maryland 21215-0020

Directo

Funeral

by

Completed

the Maryland worle

Division of Vital Records, P.O. Box 68760 To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

Registrar

31. Dete filed (Month, Day, Year) APR 0 2 1999

29b. Signatura and titla of cartifiar

W. Chrstopher Golden, MD 32. Registrer's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

, 600 No With Wolfe Street Baltimore, Maryland 21287

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated.

29c. License number

14ES-000

29d. Data signed (Month, Day, Year)

March 22, 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:15 PM Shirley 1999 V. SCOTT March 27 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Sinai of Baltimore City Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MD. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Deys 1□M 2CXF Yrs. 9-8-1937 213-36-3741 61 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD. BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3402 CALLOWAY AVE. 21215 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D\(No \) If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 2 BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS ADJUSTER S.S.A. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ISIAH SCOTT MYRTLE SCOTT 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN MOHORN 3402 CALLOWAY AVE. BALTIMORE MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEM. 4-1-99 BALTIMORE MARYLAND 21. Signatury Funeral Service Licenses 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Diabetes Mellitus, Aremia 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Fibrosis 2□No 1 ☐ Yes 2 No 1 Yes 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes ZZNo 1 Nnpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 2 ☐ Accident 5 Pending investigation 1 TYes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified as

Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me

Physician /Medical

Examiner

physician and the burial-transit

signed by the e

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After t

To Be

Certification:

Medical

29a. Certifier

29b. Signature and title of certifier

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with the Marylend

Pages 1 end 2 should be filed withIn 72 hours after death

Baltimore, Maryland 21215-0020

in 24 hours are: the Funeral Director: After matery filled in by the fur Hospital completely To the the 0

Registrar

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s)

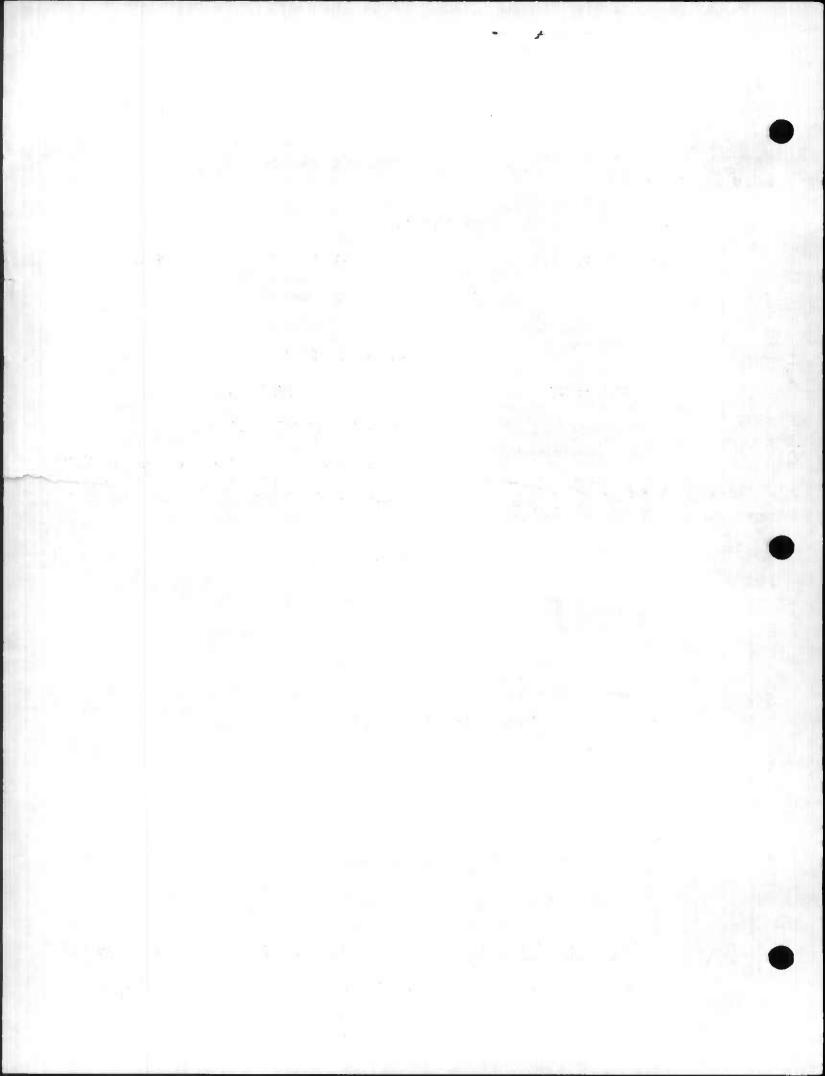
29d. Date signed (Month, Day, Year)

UMP 11227 mi)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

March 27 1999

-Davis Christophe 31. Date filed (Month, Day, Year) APR 2 Baltimore, Maryland 21215 2401 West Belxedere Avenue 32. Pegistrar's Signature 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth Month 3 28 1999 **Physician** 10:30 p.m James Shipman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, give street and number) Examiner N/A 2613 W. Coldspring Lane Baltimore If Undar 24 Hrs. Birthplace (State or Foreign Country)
 N . C . 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number **Funeral** Days Months Hours 1 M 2 □ F 246-48-8876 64 Director Usual Rasidanca of Dacedan with the Merylend 10c. City. Town or Location 10d. Insida City Limits 10e. Stata 10b. County emit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be not the first or other traumatic event, the Medical Examples must be not the XXYas 2 No Director Md N/A Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 2613 W. Coldspring Lane 21215 USA Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerlo Rican, atc.) 14. Race - American Indian Black, Whita, atc. 12. Was Decedant Evar in U,S. Armad Forcas? 1 Yes 2 No If Yas, Give Yeer or Datas: 1 Nevar Married 2 ☑ Married Specify: Black 1 Yas ZONO Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Concrete Pipe Products Elamantary/Secondary (0-12) 9th grade Collega (1-4or 5+) Fork Lift Operator 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Rudolph Shipman Martha Brunson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Mary Shipman- Wife 2613 W. Coldspring Lane Baltimore, Md 21215 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20e. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramovai from Stata King Memorial Park 4-3-99 Randallstown, Md 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
March F/H West 4300 WABASH AVENUE BALTIMORE, MD 21215 Enter the disaase, or complications that causad tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** /Medical Immadiata Cause (Final · Metastatic Gastric Concer disaasa or condition rasulting in daath) Examiner Physiclan/Medical Examiner attending physician end for use as the bunal-transit certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Box 68760 Dua to (or es e consequence of) requires that the death 23b. Did tobecco usa contribute to the ceuee of death? P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. the 3 Probably 4 Onknown 6 1 ☐ Yes 2 ☐ No signed t Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy peen s Completed The law r has 1 Yas 2 HNo 1 ☐ Yas 2 ☐ No certificata Division of Vital Physician: Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 10 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA this funeral 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28b. Time of Certification: oral Director: After I or Attending 1 Natural 5 Pending invastigation death. 1 Yes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) after 4 Homicida within 24 hours a To the Funeral D Hospital 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steled.

2 Medical Exeminer: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier edicai completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

DHMH 16 Rev 6/95

State

Ray Yaz Registrar

MIPUN

B

MERCHANT, 2435 W MD 32 F

30. Nama end address of person who completed causa of daath (Itam 23a) (Type, Print)

BELVEDERE AVE, SUITE 41

BALT MD

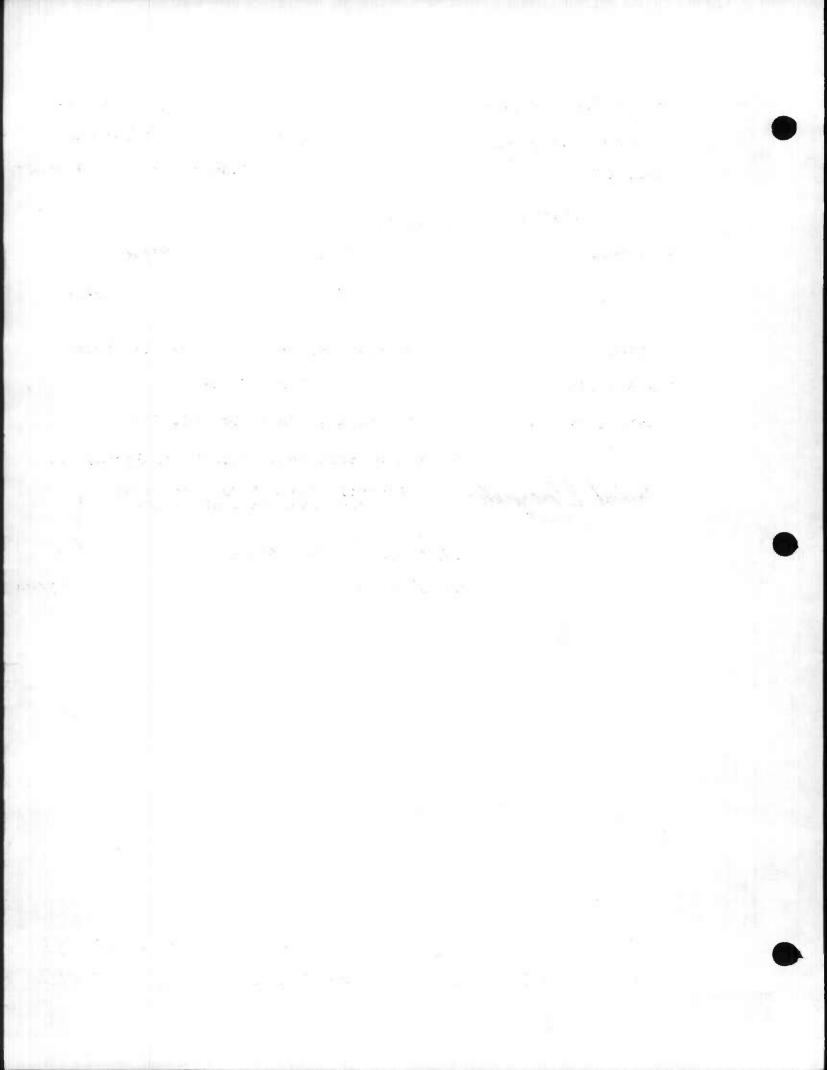
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margletha Sams
4a Facility Name (If not institution, give street and number) 1999 March 21 19:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore Sq /Tr/Murc
If Under 24 Hrs.
| 8. Date of Birth (Month, Dey, Year) | 1 ary 20, Eg Iti More DayView 5. Social Security Number If Under 1 Yaar 9. Birthplece (State or Foreign Country)
1921 Kentucky 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days 1 ☐ M 2 💢 F Yrs. 78 Director 407-20-8715 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event. The Maries. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Md. Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21222 USA 2025 Guyway Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 X No If Yes, Give Year or Dates: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker General Motors 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Berta Baker Ira Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rure! Route Number, City or Town, State, Zip Code) Baltimore Md. 21222 Donald Sams /son 2025 Guyway 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) Metro Crematory Inc. 3/23/99 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore, Md. 2

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. 21221 Approximata Interval Between Onsat and Death **Physician** Hemoringge /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner tension sician end buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immadiate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last P.O. Box 68760. Physician/Medical the Due to (or as a consaguence of) 98 use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy Completed pege 2 s 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certific. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Date of trijury (Month, Day Year) 28c. tnjury at Work? 1 Natural

Accident 5 Pending investigation 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Roufa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 24 hou To the Funer completely fil Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifiar 29c. Licensa number 29d. Data signad (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Hospital, Baltimore, MD Bayview 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #8 PER F.H. G770 4-2-99 WR. Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Sturm šĭ', 19999 Evelyn 02:45 PM MARCH /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner N/A CITY BALTIMORE THE JOHNS HOPKINS HOSPITAL If Under 1 Yeer | If Under 24 Hrs. Months Deys Hours Min. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age_(In yrs. lest birthday) 8. Date of Birth 1927 (Month, Dey, Year) **Funeral** Months 217-22-2518 Director 4/18/1999 Maryland Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner near be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Arbutus 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 5523 Heatherwood Rd. 21227 Funeral United States 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status filed within 72 hours efter 1 Never Married 2 Married Yes 2XNo altimore, Maryland 21215-0020 1 Yes 3 No Specify: Specify: Ag White 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home permit, Pages 1 and 2 should be file.
Department of Heelth and Mentel Hy, important; if them 27 is marked other any injury or other transmers of other presents. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Roper Evelyn M. Chandler 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Norman E. Sturm, Sr./husband 5523 Heatherwood Rd. Arbutus, MD 21227 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5 Other (Specify) Loudon Park Cemetery 4/3 Baltimore, Maryland 22. Name end Address of Fecility Ambrose Funeral Home, Inc/ Funeral Serv no Licenson 1328 Sulphur Spring Rd. Arbutus, MD 21227 death. Do not enter the mode of dying, such es cerdiac or respiretory errest, 23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final years ischemic cardiomyopathy diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760. Physiclan/Medical Due to (or as e consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy peed page 2 s 1 Tyes 2 No. 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this funeral 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 Netural deeth. 1 Tyes 2 No 2 Accident efter deeth 6 Could not be determined 3 ☐ Suicide 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the F 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KSlugeron, MD Res - 000 3/31/99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Keliegh Culpepper, MO Johns Hopkins Hospital, BALTIMORE, MARYLAND 21287

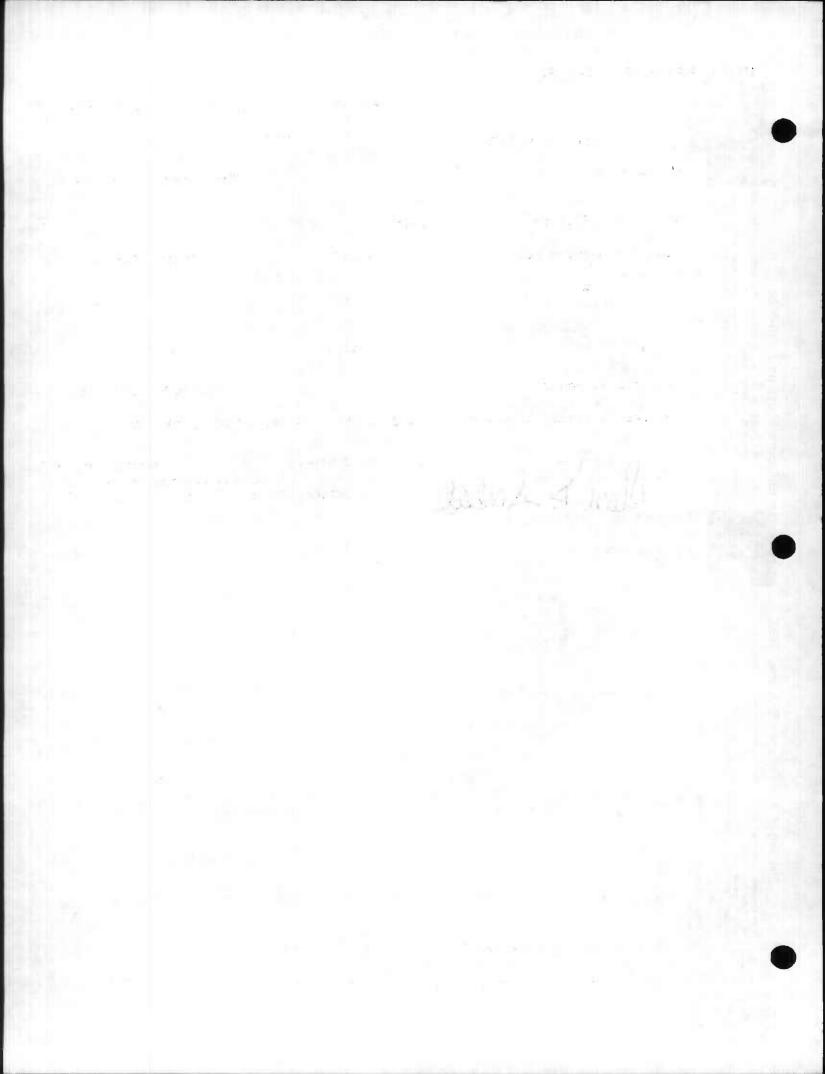
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31. Dete filed (Month, Dey, Year) "

APR

2 1999

32. Registrer's Signature



NOLOdymyR C. Sushko

	Physician	1. Decedent's Neme (First, Middle, Las	SUSHKO					2. Dete of D		9,8,2	3. Time of Deeth 1 : 10 AM	
	/Medical Examiner	4e Fecility Neme (If not institution, give Saint Joseph	street and number)	Center			4b. City, Town, o		eth 4c. Count	of Deeth	imore	
	uneral irector	5. Social Security Number 6. Sex 20 F 7. Age (In yrs. last birthday) 1 Under 1 Year Months Deys 78 Yrs.									plece (State or Foreign ntry) AINE	
pug	ž_	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location						10d. insid			10d. inside City Limits	
e Maryl	be nowled at Director	MD. BALTIMON	RE		IMORI				T		1 ☐ Yes 2 💢 No	
th.	or 2	10e. Street end Number				10f. Zip Code				10g. Citizen of Whet Country?		
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2 30		15. Decedent's Ed	ucetion	16a.	Deceden	t's Usual Occu	pation		16b. Kind of E			
within 7;		(Specify only highest grader) Elementary/Secondary (0-12)	College (1-4or 5-	+) FO	(Give kind of work done du life. DO NOT use retired) FORESTER		e during most of working ed)		DEPT. BALTIM		DUCATION	
		17. Fether's Name (First, Middle, Last)		, , ,	112011		18. Mother's N	le, Maiden Sumai	e, Maiden Sumame)			
ed be		BASIL SUSHKO MARIA						KULCHIT:	CKA			
shou M		19a. Informant's Name/Relationship (7	Type, Print)	19b	. Mailing /	Address (Stree	at end Number or I		~	, State, Zi	p Code)	
nd 2	trac	OLHA SUSHKO/WIFE		58	n7 rr	MSTOCK	AVENUE	RALTIMO	DE MD 2	1206		
H98	ges 1 end t of Health if item 27 or other tr	20e. Method of Disposition	20b. Plece of Disposition (Name of cametery, crematory or other place)					Dete	20c. Location	- City or T	own, Stete	
Pages	as Bo	XXBurial 2 Cremetion 3 4 Donetion 5 Other (Specific	Removel from Stete					h (C (00	DA1 7714	005 1		
9 1	right.	21. Signature of Funeral Service Licen		51. MI			AINIAN ress of Fecility	4/6/99	BALTIM	URE, M	D.	
permit Depart	Important: It any injury o once.		16	7 /	LILL	Y & ZE	ILER INC	. FUNER	AL HOME			
		23a. Part1. Enter the disease, or comp	SALAR.		1901	LEASTE	RN AVENU	E, BALTI	MORE, MD.	2123	Approximete	
/M	sician edical iminer	shock, or heart failure. List only immediate Ceuse (Finel disease or condition resulting in death)	METASTA	e ATIC C	ANCE	R	•				Intervel Between Onset end Death MONTHS	
	6		ı	Due to (or as e consequence of):								
certificate be executed	been signed by the attending physician and should be deteched for use as the bunel-trensit leted by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initileted events	b	Due to (or es e	conseque	nce of):						
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tificat	es the bur	resulting in deeth) Lest	Due to (or es e consequence of):									
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900	he at led fo	Pert II. Other eignificant conditions co	ontributing to death bu	t not resulting in	the unde	orlying cause g	iven in Pert I.	23b. Di	id tobacco uee c	ontribute	to the cause of death	
s that the	igned by the att be dateched fo by Physicia	HYPERTENSION						- 1	□ Yes 2□ No	3□ Pro	obably 4 Unknow	
The law requires that the dee	sete has been signage 2 should be Completed	LIVER FAILURE						performed? eveilable prior			Vere eutopsy tindings veilable prior to completion of cause of deeth?	
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sich	I dirac	examiner? 1 ☐ Yes 2 ☐ No	Hospitel:	nt 2 ER/Ou	tpatient	3□ DOA O	ther: 4 Nursing	Home 5□Re	sidenca 6 🗆 Ot	her (Spec	ify)	
P.	eration in I	27. Manner of Death	28a. Dete of Injur (Month, Dey	y 28b.	Time of	28c. Inj W			e how injury occu			
ding.	e fun	1 □ Naturel 5 □ Pending 2 □ Accident investigation		1007)	njury		Yes 2 No					
Hospital or Attending Physician: 24 hours after death.	al Director: After this certificate has led in by the funeral director, page 2 Certification: To Be Comp	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify))	28f. Location City or 1	(Street end Num Fown, Stete)	ber or Ru	rel Route Number,	
B Hospita 24 hours	To the Funeral Director: A complately filled in by the fundamental Medical Certification		ysicien: To the best on hiner: On the besis of end menner sta	examinetion en								
To the	omplo Me	29b. Signature end title of certifier				29c. Licer	nse number		29d. Date sign	ed (Month	, Day, Year)	
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	11) WV	30. Name end eddress of person who					TOWS	IN MOF	TIME IVE	2120	14	

State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

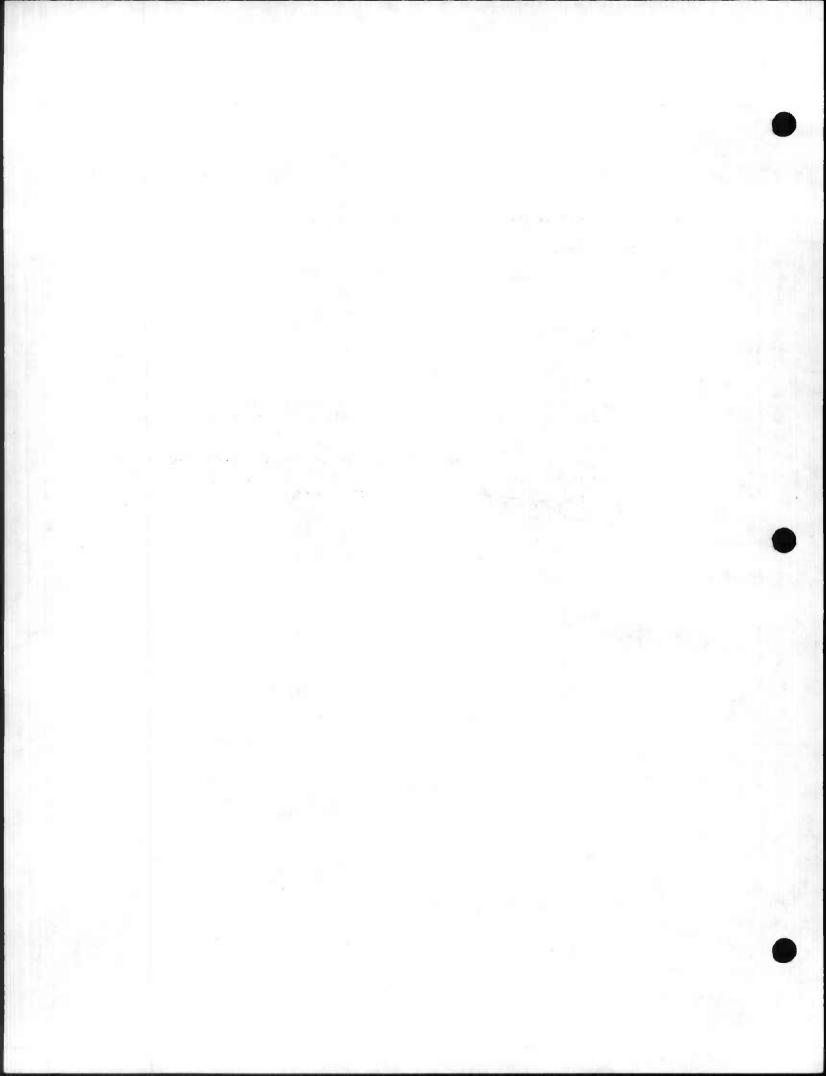
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State of Maryland / Department of Health and Mental Hygiene 99 10666

					Certificate of	Death	Re	g. No.		100000	
		1. Decedent's Name (First, Mide	tia, Last)				2. Date of Death	1	Vall	3. Tima of Death	
	Physician	LOUISE	SUZAN		SLED	7.	Month APRIL 1		Year	10:30 PM	
	/Medical Examiner	4a Facility Nama (If not institution		er)	2020	4b. City, Town, or L		4c. County of	f Death		
	Cxammer	MARINER HEALTH	the state of the s			GLEN	BURNIE			ARUNDEL	
	uneral irector	5. Social Security Number 219-54-4569 6. Sex 1 Months 1 Months 2 F Social Security Number 219-54-4569 7. Aga (In yrs. last birthday) 4. Months 50 4. Months 50 4. Deys 4. Months 6. Deys 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 8. Deta of (Months) 9. OCT.							th, Day, Year) Country)		
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th with th	23a or 28a-fs unt be notified ai Director	10a. Street and Number 313 HOSPITAL DI	RIVE		10f. Zip Code	21061	10	10g. Citizen of What Country? U.S.A.			
21215-0020 d within 72 hours after death with the Manyland	'natural', or tems 23a or 28a-f show addal Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed W Divorced 12. Was Decedent Armed Forces? 1 Yes 20 If Yas, Giva Year or Dates:		s? No	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify: 11☐ Yas 2☒ No Specify: 12☐ Yas 2☒ No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yas or No- Black, Whita, a					atc.	
22 P	ed within 72 ho bygiene. or than "naturn it, the Mandell	15. Deceda	nt's Education ast grade complated)	16a	. Decedent's Usual Occu (Giva kind of work done	pation a during most of work	tina 1	6b. Kind of Bus	iness/Inc	yrteut	
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≥ p €	10 m	19a. Informant's Name/Ralation WILLIAM G. HAR			o. Meiling Address (Stree 207 SYCAMORE						
Baltimore,	= -	20a. Mathod of Disposition		comete	f Disposition (Nema of ry, crematory or other plants	ece)	Data 2	0c. Location - 0	City or To	wn, Stata	
Peges Peges	7 9	tX☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (la	RIDGE MEMOR		4/3/99 EI	LKRIDGE	. MD		
alti.	pemit, Pege Department of Important: If any Injury or once	-	Licensee		22. Name and Addi					ME, P.A.,	
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Of Vita Physician:	certificate rector, pag	25. Was case raferred to medic axaminar?					th (Check only one)			
- 5	this ce al dire	1 Yas 2 No	Hospital: 1 ☐ Inpa	itiant 2 ER/O	utpetient 3 DOA	ther: 4 Nursing Ho	oma 5 Resider	nce 6 Otha	r (Specif	y)	
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VISION Attending	ne fu	2 Accidant invas	tigation			Yas 2□No					
DIVISION for Attending after deeth.	al Director: After to led in by the funers Certification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide deten	mined 208. FIREST	Injury - At homa, fa atc. (Specify)	arm, street, factory, office	9	28f. Location (Str. City or Town,		r or Rura	al Routa Number,	
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Hospit 24 hour	To the Funeral Director. After thi completely filled in by the funeral Medical Certification: 1	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the besi Examiner: On the basis and mannar	of examinetlon en	e, death occurred at that d/or investigetion, in my	time, date and place, opinion, deeth occur	end due to the ca red at the time, da	use(s) end mar te end piace, a	nnar es si nd due to	tated. the cause(s)	
o the	ompl Me	29b. Signature and fitle of cartifi	111111111111111111111111111111111111111		29c. Licer	ise number	29	d. Data signed	(Month,	Day, Year)	
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		1 mil	1000	metra	Jun 7	10 18	7	7	19	17)	
		30. Nama and addrass of person	who completed cause of	death (Item 23a)	(Type, Print)	lan Be	mer,	MOS	40	61	
	State	31. Dafa filed (Month, Day, Year		strar's Signature	4 1	32		-			
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DHMH 16 Rev 6/95



State Registrar

DHMH 16 Rev 6/95

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Name and address of person who

31 Date filed (Month, Dey, Year)

32. Registrar's Signature

completed cause of death (item 23a) (Type, Print)

rut no

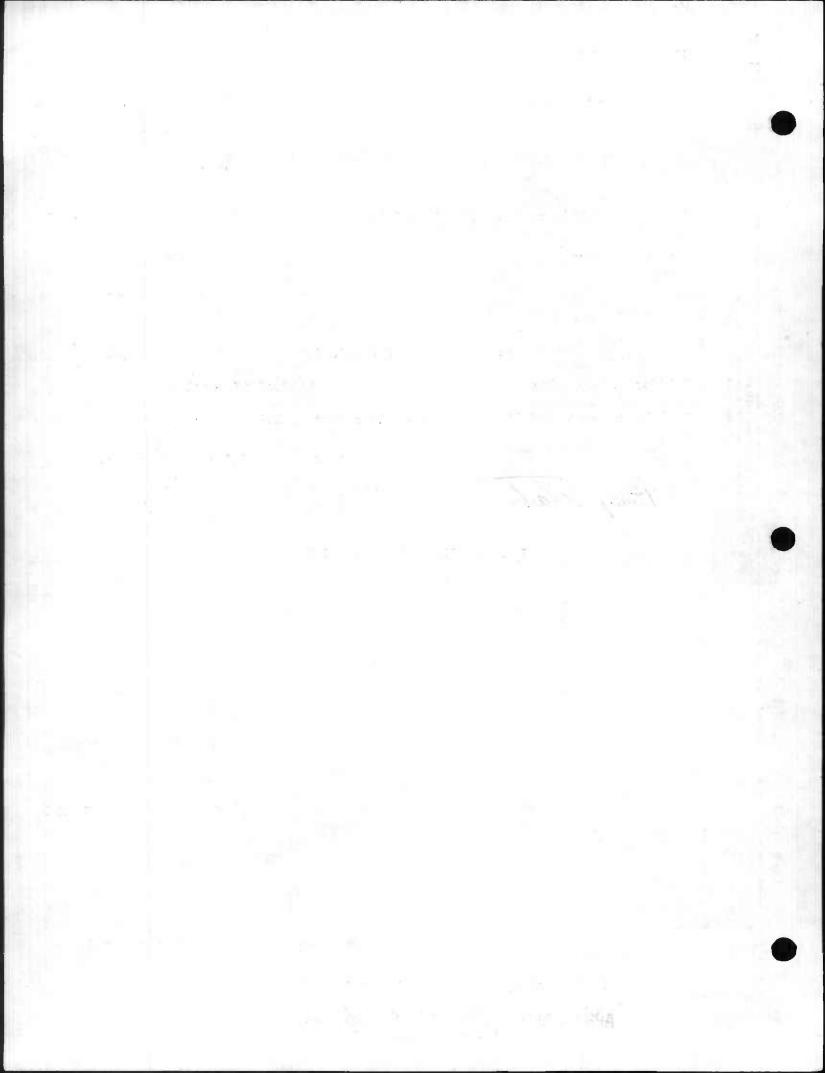
MD

B. Sports

OCME

111 Penn Street, Baltimore, Maryland 21201

MARCH 30, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 1459 J. SPEIDEL MARCH 25, 1999 EANNE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE N/A UNIVERSITY OF MARYUMO MEDICAL SYSTEMS If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) Deys Hours 1□M 2□F 217-13-4702 27 Yrs AUG. 26, 1971 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County MD 1 Yes 2 No Howard Elkridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8015 Greentree Court 21075 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 11 Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1□ Yes 2□No Specify: white 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 4 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Marsha Stollings Ronald Thorpe 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8015 Greentree Court, Elkridge, Md. Donald L. Speidel - husband 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 3/29/99 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21, Signature of Funeral Service License Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Bety Onset and Death Immediate Cause (Finel disease or condition resulting in death) a Sepsis - overwhelming bacterial SANG S Due to (or as e consequence of) Acute lymphousic Leukemia 2 YEARS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) that initieted events resulting in death) Last Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of ceuse of deeth? *24a. Was an autopsy performed? 20 No 1 ☐ Yes 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only one) exeminer? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 1 Natural 2 Accident 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

MARCH 25, 1999

the deeth certificate be axecuted Division of Vital Records, P.O. Box 68760, or Attending Physician: n 24 hours after death.

• Funeral Director: After the function by the function of the functin To the Hosp within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

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r than "naturel", or items 23a or 28a-f ahov the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If fem 27 is marked other any lojury or other traumatic avent page.

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filed within 72 hours efter Hygiene.

Baltimore, Maryland 21215-0020

State Registrar

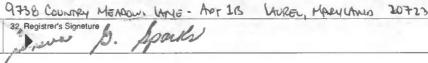
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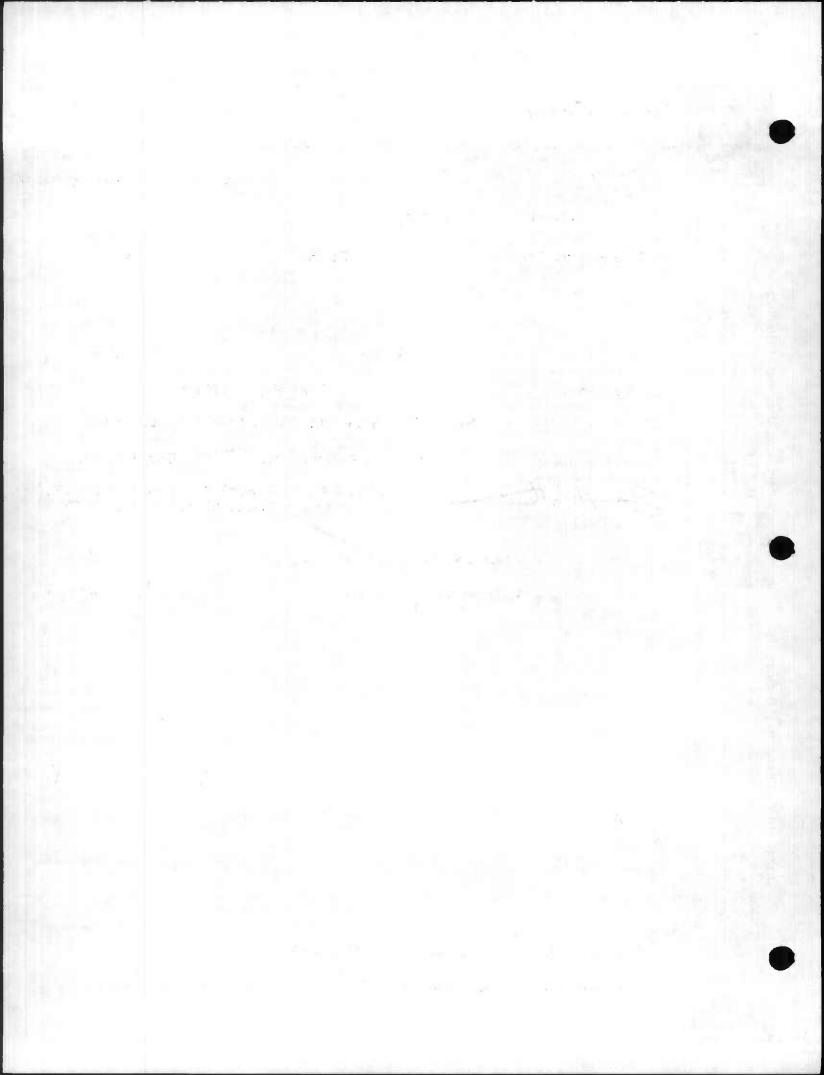
More

29b. Signature and title of certifier



wherely

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Yea **Physician** SALKOWSKI 1745 DOROTHY 99 E. 03 31 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Deeth Examiner BALTIMONE
H Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
(Month, Day, Year) MARYLAND UNIVERSITY OF Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 ☐ M 2 ☐, F Yrs. JULY 16, 1920 Maryland Director 220 14 6088 Usuet Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at XX Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA permit. Pages 1 and 2 should be filed within 72 hours efter death Dependment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23. Funeral 1211 West Lombard St. 21223 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Thiel Margaret Bell 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Haupt 101 H Waldon Rd., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 0 Injury Balto/Wash Crematory 4/3/99 Laurel, MD 21. Signeture of Pynerai Service Licen 22. Neme and Address of Facility Gary L. Kaufman Funeral Home @Meadowridge Pk.Inc. 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a shock, or heart failure. List only one ceuse of each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) SEPSIS Examiner Due to (or es a consequence of): Physician/Medical Examiner URINARY TRACT INFECTION ettending physician end for use as the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or as a consequence of): 88 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No BRONCHITIS þ 24b. Were autopsy findings eveileble prior to 24e. Was en eutopsy Completed peen s CHRONIC OBSTRUCTIVE LUNG DISEASE completion of cause of deeth? has 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Piace of Deeth (Check only one) To Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours efter deeth. the Funeral Director: All apletely filled in by the fu deeth. 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I

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State Registrar

with the Maryland

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Division of Vital Records,

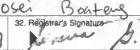
or Attending Physician:

Hospital

31. Date filed (Month, Day, Yeer) APR 1999

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29b. Signature end title of certifier



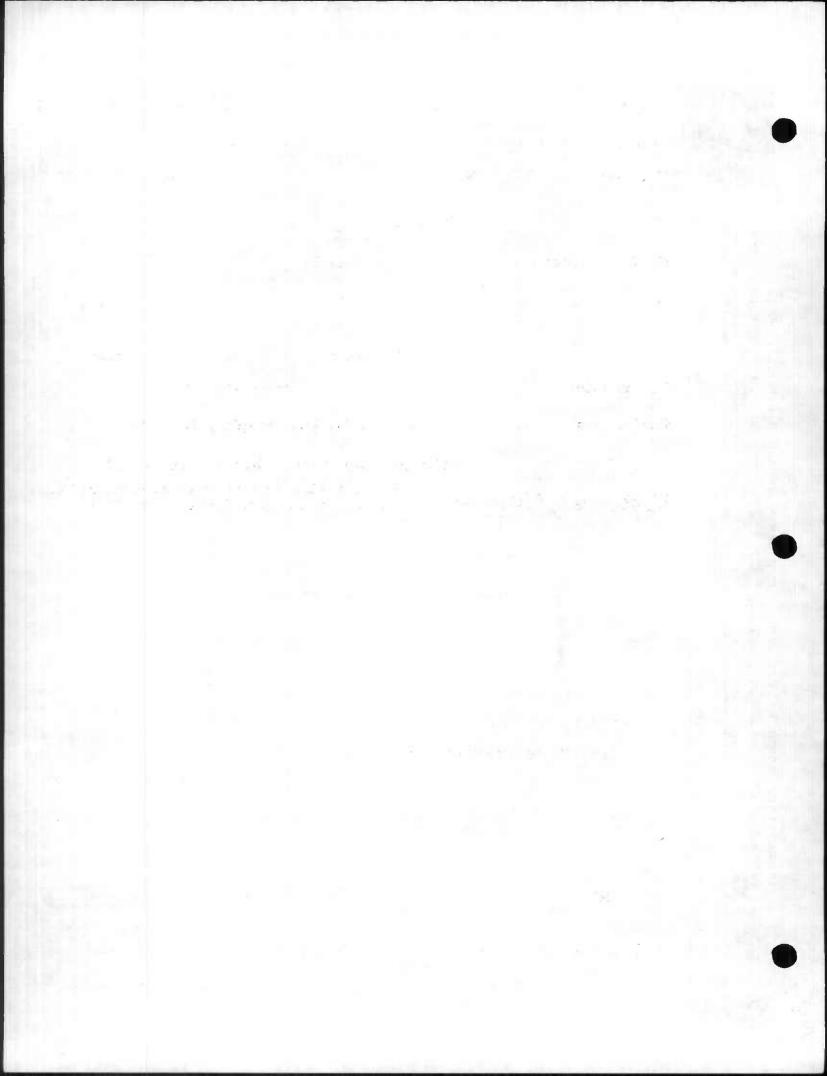
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30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

27 South Greeke St, Bulhmore



YEAR

2. DATE OF DEATH

3. TIME OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

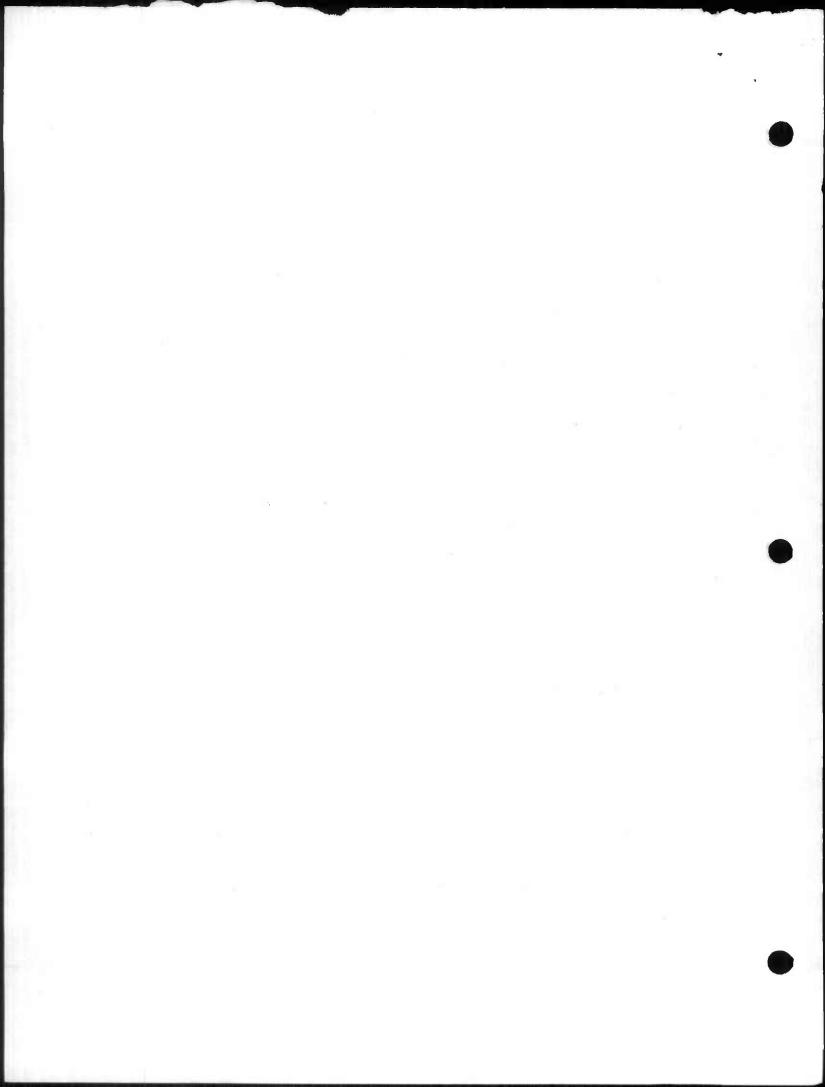
LORRAINE MONTH NOV. DAOMI IILLHAN 8:15A 6. BIRTHPLACE (State or Foreign Country)
Mary / AND 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 3-14-9760 DAYS HOURS MIN. JUNE funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and numb 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE Cylburn NA DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE Hary Pro 1 YES 2 NO FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? CYLBURN USA 2/2/5 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cupan, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married specify: Black BY 3 ₩Idowed 4 □ Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Private RESIDENCE Elementary/Secondary (0-12) College (1-4 or 5+) NUISE Practical 4EARS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S, NAME (First, Middle, Maiden Surname) GREEN BONDLEY ALEXANDER LIllIAN notified at 19e. INFORMANT'S NAME (Type/Print) BOLHNURE, HORY INXO CYLBURN AUG TEAN JONES Drugher pe 20e. METHOD OF DISPOSITION

1 Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION — City or Town, State must Owings 22. NAME AND ADDRESS OF FACILITY CHIPTY
52 VO RUSTERS TO UNA
24. LL LOYE LO 2 Donetion 5 Other (Specify) 21. SIGNATURE OF EUNERAL SERVICE LÉCENSEE examiner Harris 21211 and completely filled in by the burial, cremation, or removal. medicai 23. PART 4. Enter the disea Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pr heart fallure. List pnly one cause on each line. Approximata interval Batween Onset and Death IMMEDIATE CAUSE (Final the disease or condition resulting in death) ANEMIA MONTH HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CASTROINTESTENAL BLEEDING 1 MONTH CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DIRECTOR: After this certificate has been signed by the attending physician at hours after death with the State Dept. of Health and Mental Hygiene prior to I flem 28 is marked, or Item 23 shows any Injury, or other trauma If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL PERFORMED? AVAILABLE PRIOR TO ENDOCAROJTIS, CONLESTIVE HEART FATLURE COMPLETION OF CAUSE OF DEATH? 1 TYES 27 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home 5 | Re 1 Inputient 2 ER/Outputient 3 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Routa Number, City or Town, Stata) 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If IN MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 00053183 MARCH 31, 1999 M.D 2 30. NAME AND ADDRESS LETED CAUSE OF DEATH (ITEM 27) (Type, Print) EMIL HAYEL K.D EAST UNIVERSITY PARKWAY 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE ,ever rocks APR 2 1999

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 40 Am 20540 nomas 10 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (It not institution, give street end number) Examiner Baltimore Hos pital If Under 1 Yeer If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lesf birthday) **Funeral** 12 M 2 F Months Days Hours Min Yrs. 214-07-8570 Ma **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Nes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a . S.A Ambrose 21215 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Mayes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Baltimone permit. Pages 1 and 2 should be lited within Department of Health and Mental Hygiene, important: if item 27 is marked other than " any injury or other traumatic event, the Mes oondary (0-12) College (1-4or 5+) Service A Postal ingrade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Dessie Deare YOP hee Inomas 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a Informant's Name/Relationship (Type, Print) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Balto, Md Ambruse 2/215 eorgette - Daughter young 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4-5 Ma MILLS Forest Va 4 Donetion 5 □ Other (Specify) nourison 22. Name and Address of Facility 21. Signature of Fun rel Service Licenses 21215 12a 140, Md 30 Wabast Approximate Interval Between Onset end Deeth fart1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Aspiration Examiner Examiner Jascule physician and the buriel-transit Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medicai Due to (or as a consequence of): 50 for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed page 2 s certificate has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending s effer deeth. 2 No investigation 1 Yes 2 Accident 6 ☐ Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 - Homicide 24 hours e Funerai E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es steted. edicai 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29d. Date signed (Month, Dey, Year)

Baltimore, Maryland 21215-0020

that the death certificate be exec

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Yeer) 2 1999

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30. Name end address of person wild

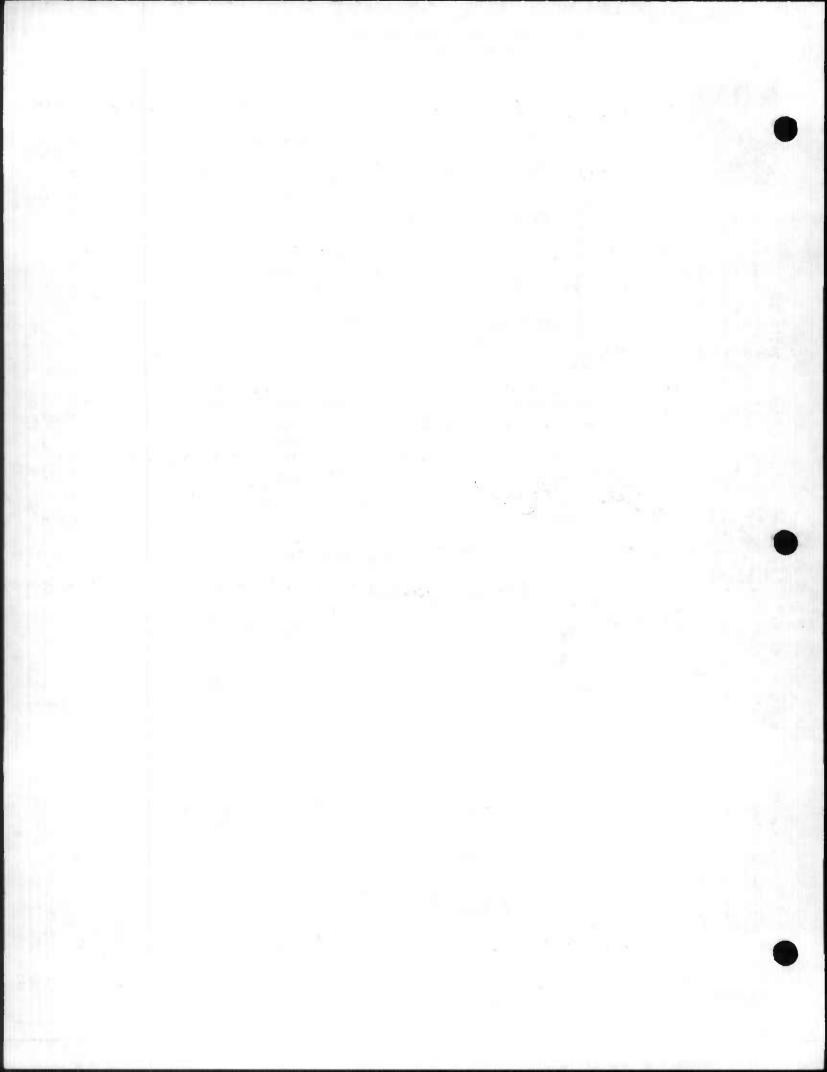
MIBINI MID 32. Registrar's Signeture

completed cause of death (Item 23a) (Type, Print)

SINA MOSPITAL

OF BALTIMORIE, 2401 W. BELVEDERE

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

GLEN A. TROYER Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month APRIL **Physician** Glen Albert Troyer 1999 0255 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 123 HOUCK ROAD WESTMINSTER CARROLL If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number Date of Birth (Month, Day, Year) ug. 16, 1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 20 F 212-50-1845 Yes Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location ahow r then "netural", or Rema 23a or 28a-f ahov the Medical Examiner must be nothed at Md. 1 Yes 2 No Carroll Westminster **Funeral Director** 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Houck Road 21157 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or hen any injury or other traumatic avant, the Medical and any Bleck, White, etc. Yes 2000No f Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 20(No Specify: Specify: þ White 3 Widowed 4 Divorced Yeer or Detes: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) State of Maryland Plumber 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Donald Albert Troyer Kathleen M. Hastings 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Code) 123 Houck Rd., Westminster, Md. 21157 Friend Debra P. Eckard 20b. Pleca of Disposition (Name of cametary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Evergreen Mem. Gardens April 5, 1999 Finksburg, Md. 21. Signature of Fund 22. Name and Address of Facility
Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner ase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of) use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

The law requires that the death certificate be executed Division of Vital Records, P.O. by edical Certification: To Be Completed To the Hospital or Attanding Physician: illed in by the funeral director, After this death. after death

25.

27.

30. Name

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29b. Signetura end title of certific

		1 Yes 2 No 3 Probably 4 Unknow							
		24a. Was an autopsy performed? Limited 1 2 Yes 2 No 24b. Ware autopsy findings available prior to completion of cause of death? 1 2 Yes 2 No							
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
XX Yes 2 No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	(Month, Day Year) tnjury Work?	8d. Describe how injury occurred							
3 Suicide 6 Could not be datermined	28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rurat Route Number, City or Town, Stata)							
	ysician: To the best of my knowledge, death occurred at the time, date end place, ar illner: On the basis of examination and/or investigation, in my opinion, deeth occurred end manner stated.								

29c. License number

O.C.M.E

29d. Data signed (Month, Day, Year)

APRIL 1, 1999

State Registrar

DHMH 16 Rev 6/95

within 24 hours a To the Funeral C

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address of person who complated cause of death (Item 23e) (Type, Print)

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111 Penn Street, Baltimore, Maryland 21201

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	Margaret Janet Vares							TRUH	311	1999	7:18
	4a Facility Nama (If not institution, give street end number) 4b. City, Town, or							n of Death	4c. Cou	inty of Deal	th
4	Stella Maris	at Merc	y Hos	pice	I Hilladas 1 V	Balti		15:0	n/a		
		Sax 7. 1 ☐ M 2 ☐ F	Age (In yrs. I	last birthde. Yrs.	y) If Under 1 Y Months De	aar if Undar 24 ays Hours	Min /A	ata of Birth Nonth, Dey 15-1	Year)	Co	thplaca (Stete ountry)
ł	213-30-0951A Usual Rasidanca of Decedent	- Aur						T2-1	.933	Balt	imore,
	10a. Stata 10b. County		10c. City	, Town or	Location						10d. inside C
	MD	n/a	Bal	ltimo	re						1 Yas
To Be Completed by Funeral Di	10e. Street and Number				10f. Zip Co	da			l0g. Citizan	of What Co	ountry?
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	3 ☐ Widowad 4 ☐ Divorced	as:	16a Dor	cedent's Usual O	ccunation			16b. Kind o	of Business	Andustry	
	15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Gi	ve kind of work d . DO NOT use re	one during most of	of working	- 1			ce of
	Elementary/Secondary (0-12)	Legal Secretary							,Grimes		
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	Joseph Dannenfel:			Kath	nleen	Ruth					
	19e. Informant's Name/Ralationship	19b. Ma	iling Address (St	treet end Number	or Rurel Ro	ute Numbe	r, City or To	wn, Stete,	Zip Code)		
	James P. Vares					treet, I		-			
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State Registrar

Division of Vital Records, P.O. Box 68760,

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who

pleted ceusa of daath (Item 23a) (Type, Print) Lis chers 32. Registrar's Signatura

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Paul Pl

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item 23 Part I a Per PHY FilmG770 4-2-99 rja 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Day **Physician** ALBERT G VOJIK 8:25 PM 1999 28 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Church Hospital Baltimore N/a | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 28, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Funeral Months 180M 2□ F Maryland 213-01-8939 87 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c City Town or Location or 28a-f show 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 839 W. Linwood Avenue 21205 U. S. A. ms 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Engineer Aerospace 12th Grade 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Haaith and Merenant: If them 27 is mented Saltimore, Marylar Elizabeth Bocek Charles Vojik 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnformant's Neme/Relationship (Type, Print) nt of Haalth a if Item 27 is or other tra 8003 Caradoc Drive, Rosedale, Albert G. Vojik Jr. (Son) Maryland 21237 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removet from Stete 3/31/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Buan Ce Schimunek Funeral Home Inc. Willen 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Pulmonary Edema **Physician** /Medical Immediete Cause (Fine 2 WEAKS disease or condition resulting in death) Examine Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 1 Tyes 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To TO Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 846 27. Manger of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. tnjury at Work? 28d. Describe how injury occurred Affiar 1 Malatural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after desit e Funeral Director: 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide ò Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and manner stated. adical 29a, Certifier (Check only one) Within 2 2 29c. License number 29d. Dete signed (Month, Day, Year)

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State Registrar

DHMH 16 Rev 6/95

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Dete filed (Month, Day, Year)

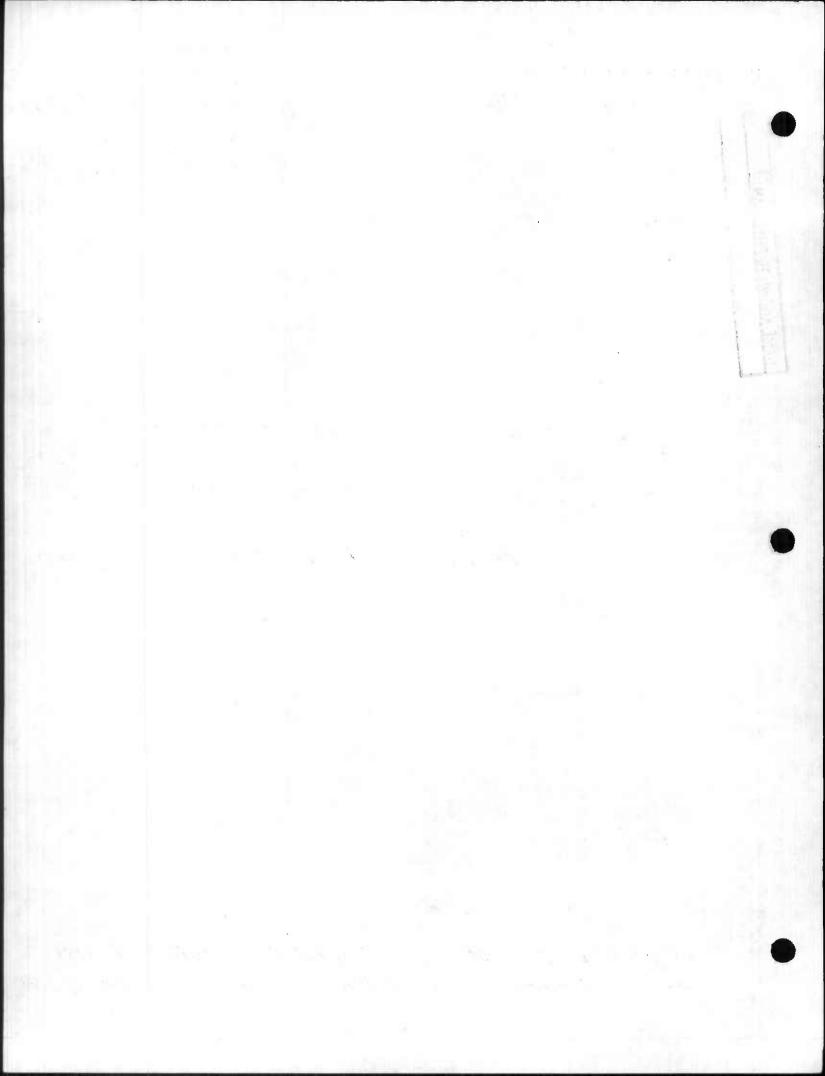
32. Registrer's Signeture

CHUREH

and address of person who completed cause of death (Item 23a) (Type, Print)

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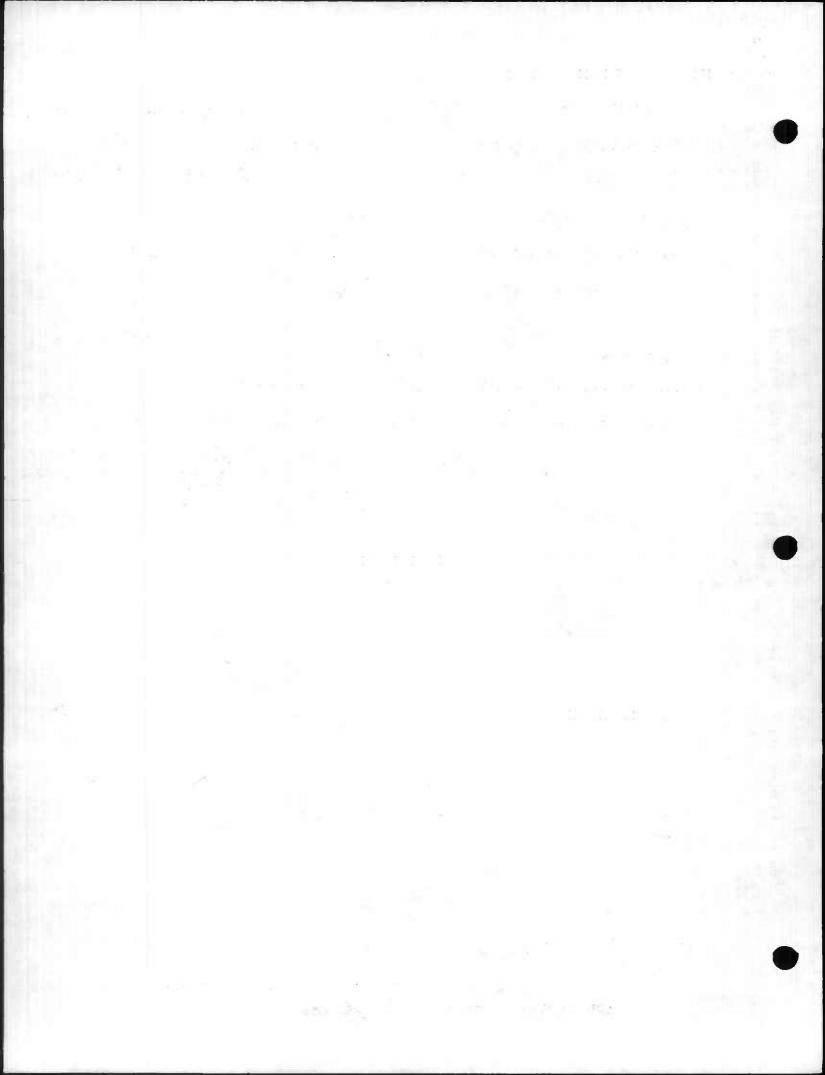
, 100 N. BROADWAY, BACUMORE MD 2031



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			State of Maryland / Department of He	ealth and Mental Hygiene	0
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Physician	MS: #23 PART I, II, 27 1. Decedant's Nama (First, Middla, La		4-9		2. Data of Deat Month	ng. No. h Day	3. T	ima of Death				
· /Medical			72670					2:05 PM				
Examiner	4a Facility Nama (If not institution, gi				Location of Death	4c. County	of Death					
Euperal	MARYLAND GENERAL 5. Social Sacurity Number 6.	J HOSPITAL Şax 7. Aga (in yrs.		BALTIMOR lar 1 Yaar If Undar 24 Hrs	8. Data of Birth		9. Birthplaca (S	Stata or Foraign				
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natural, or items 23a or 28a-f ahow idical Examines must be notified at leted by Funeral Director	11. Marital Status 1 Nevar Marriad Married 3 Widowad 4 Divorced	12. Was Decedant Evar in U Armed Forcas? 1 BYas 2 No 19 If Yes, Giva Yaar or Datas: 19	1□ Yas	cedent of Hispanic Origin? (Specify Cuban, Maxican, Pual 22 No Specify:	Specify Yas or No- rto Rican, atc.)	14. Race - American Indian, Black, Whita, atc. Specify: Black						
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Important: If It any injury or o	21. Signature of Fugeral Service Lightnees 22. Nama and Addrass of Facility CHA THAN HARRIS FUNDOL Home 5240 NEISTENSTONN LOAD BOHHHUR, M. d. 212 17											
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To the Funeral Directo completely filled in by th Medical Certific	29a. Cartifier 1 Certifying P (Check only one) 1 Medicaf Exa	hyalclan: To the best of my kno minar: On tha basis of axamina and mannar statad.	wiedge, death occurre tion and/or invastigati	ed et the time, date end pled on, in my opinion, daath occ	e, end due to the courred at tha tima, d	ausa(s) and me ata and place,	ennar as stated. and dua to the c	ause(s)				
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	30. Name end eddress of person who	complated causa of daath (Iter	n 23e) (Type, Print)									
	1 Do T (1	111 -	Street, Balti			21201					



State of Maryland /	Department	of Health and	d Mental	Hygiene	9

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month Yeer **Physician** 26 1999 Geraldine Williams March 11:40 A.M. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2914 Liberty Dundalk Baltimore Parkway If Under 1 Yeer | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Days 1□ M 25 F 83 Yrs. Director 187-14-9962 Oct. 21,1915 Pa. Usuel Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Md. Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 2914 Liberty Parkway 21222 U.S.A. Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. semil. Pages 1 and 2 should be filed within 72 hours efter of parameter of Health and Mental Hygiena. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) Secretary Steel Company 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be 0 Thomas Williams Emma Ryder 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8231 Peach Orchard Dr. Baltimore, Maryland 21222 Alma J. Shook 20b. Place of Disposition (Neme of cemetery, cremetery or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Balto-Wash. Crematory

22. Name and Address of Facility 4-1-99 Laurel, Maryland of Funeral Service License Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate friends a Rehman. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel SCUD Immediate diseese or condition resulting in deeth) Examiner Examiner ettanding physician and for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Olseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): that the death certificate be axed P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Demontia. Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed Depression. page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funarai director. 25. Wes case referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) P 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28c, Injury et Work? Certification; 27, Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homleide • Funeral 29a. Certifier 154. Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. edicai To the Hosp within 24 hou To the Fune completaly fi (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier D0034249 30. Neme and address of persols who completed cause of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar p. porks Lincola

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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 06:35 28 MARCH /Medical 4b. City. Town, or Location of Death 4e Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Data of Birth (Month, Day, Year) Peb. 16, 1911 New York If Under 1 Year If Under 24 Hrs 9. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 19 M 2 F Yrs. 090-03-9475 88 Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md, Yes 2 No Director N/A Baltimore 10e Street and Number 10f. Zin Code 10n Citizen of What Country? U.S.A. 21218 East University Parkway #505 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White P 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Law Law Enforcement 12 4 17. Fether's Name (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumama) Anna Smith William Wighton 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raletionship (Type, Pnint) John L. Wighton / Son E. University Pkwy., Balto., Md. 21218 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, crematory or other place) 3-31-99 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Balto.-Wash. Crematory Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Service Licensee Bradley-Ashton-Matthews Funeral Home, Inc. 21222 2134 Willow Spring Rd., Balto., Md. 23a. Pert1. Entar tha disaasa, or complications that caused tha death. Do not entar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximeta Intarval Between Onset and Death Immediata Causa (Fine Spiva York disaasa or condition rasulting in death) Dua to (or as a consequence of) R Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury Dua to (or as a consequence of). Physician/Medical thet initieted evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown (aranoma þ 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Vas 2 □ No 1 ☐ Yas 2 No 25. Was casa rafarrad to medical axeminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) To 1 Tas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 TYes 2 No 2 Accident 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edica 29a, Certifier /Check only one/

Box 68760 P.O. Division of Vital Records. The To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely lilled in by the funeral

Funeral

Director

28a-f show

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items 23a

traumetic event, the Medical Examiner must be notified at

the Maryland

72 hours after

parmit. Peges 1 end 2 should be filed within 72 hours atl Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event. the

Physician /Medical

Examiner

physician and the burial-transit

the

this funeral

Baltimore, Maryland 21215-0020

State Registrar

2 1999 **DHMH 16 Rev 6/95**

nd address

29b, Signature

32. Regis rar's Signatura

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to completed causa of death (Item 23a) (Type, Print)

Ave

29c. License number

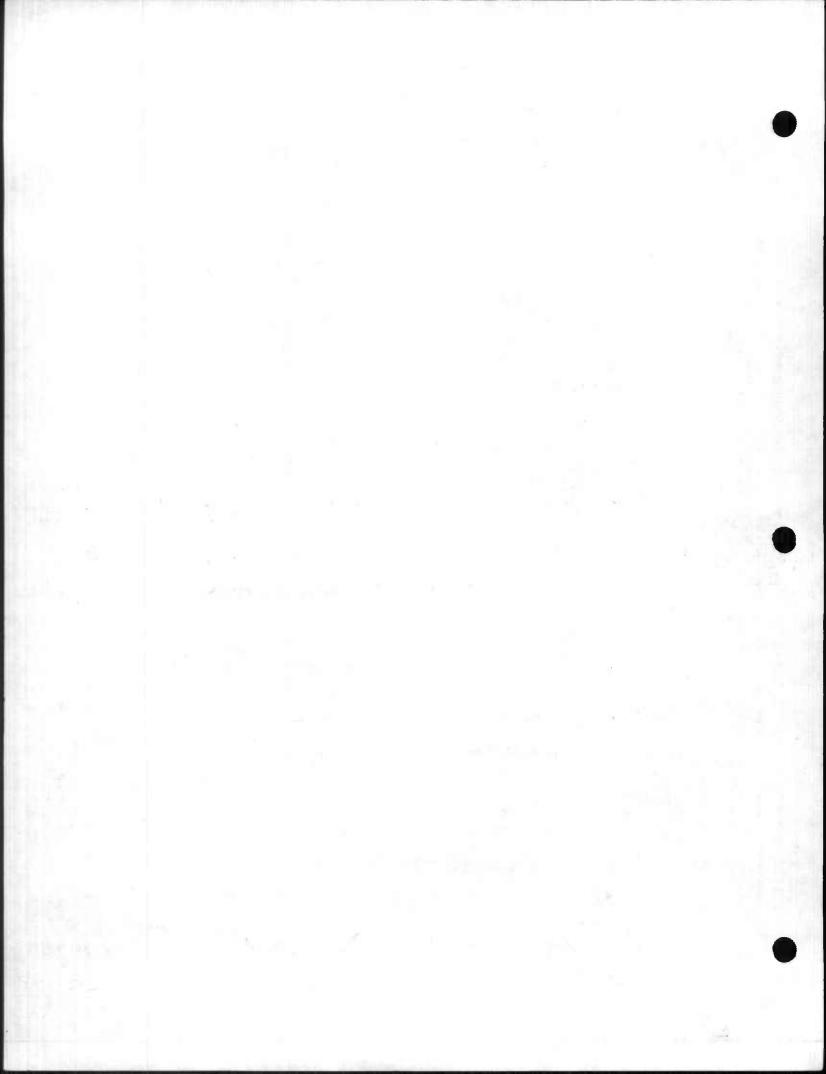
29d. Data signed (Month, Day, Year)

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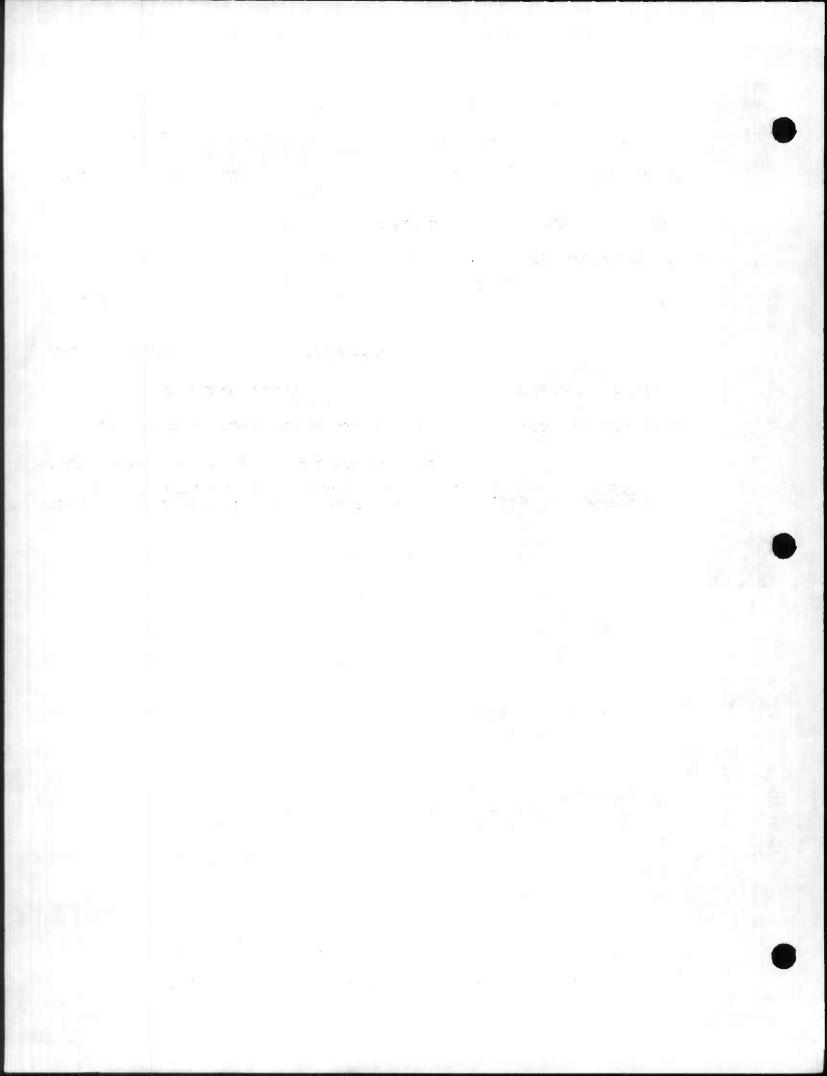
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State of Maryland / Department of Health and Mental Hygiene

					ificate of	Death		Reg. No.	105/8
Physicia /Medica		1. Decedent's Name (First, Middle, Last HELEN	w1	LMO	WIC	Z	2. Dete of D Month MARCH	Dey	Year 999 0225A
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		NORTHWEST	HOSPITAL		If Under 1 Year	RANDAL If Under 24 Hrs.			LTIMORE
Funeral Director		5. Sociel Security Number 6. Se 213-28-8275 Usual Residence of Decedent	7. Age (In yrs		Months Deys		(Month, D	0 1913	Birthplace (Stete or Foreign Country) POLAND
show show		10a. Stete 10b. County	10c. C	ity, Town or Loce	tion				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
or 28a-f sho be notified at	Director	MD N/A 10e. Street and Number		BALTIMOF	E 10f. Zip Code		-	10g. Citizen of V	Whet Country?
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21215-0020 d within 72 hours after gighten. "restural", or the explain "restural", or the the Medical Examine	py	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:		Yes 212 No		riican, etc.)	Specify	
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A Monday	To	19e. Informant's Name/Relationship (7)		19b. Mailing	Address (Stree	t end Number or Run			Stete, Zip Code)
- 5 5 5 5		WANDA ORMS, DAUGHT	ER	922 AC	ADEMY A	VENUE, OW	INGS M	ILLS. MD	21117
Baltimore semit. Pages 1. Separament of He mportant: if then my injury or oth inse.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □F		Place of Disposi cemetery, creme	ion (Neme of		Date		City or Town, Stete
Page Page ment if uny or		4 Donation 5 Other (Specify)		OLY CROS	S CEMET	ERY 4	/1/99	BALTIM	ORE, MARYLAND
Salt mention my in	1	21. Signature of Funeral Service Licens	68		Name and Addr	ess of Facility	פעד פווי	MEDAT HO	ME INC
m 20288		+ Hully X	Hack	300	O EAST	BALTIMORE	ST.	BALTIMOR	E, MD 21224
		23a. Part 1. Enter the disease, or compleshock, or heert failure. List only of	ications that caused the dee ne cause on eech line.	th. Do not enter	the mode of dy	ing, such es cardiec	or respiratory	errest,	Approximete Interval Between
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\$8760, icate be executed physician and s the buriel-transit	edical Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Imediate infying infury						
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D thet	V P	17 7 PE 12	ENSION)			11	Yes 2□ No	3 Probably 4 Dunknow
Division of Vital Records, P.O. Box or Atlanding Physician: The law requires that the deeth certafter deeth. Director: After this certificate has been signed by the ettendin in by the funeral director, page 2 should be detected for use	Completed by Physician/M						24e. We	es en eutopsy formed?	24b. Were eutopsy findings available prior to completion of cause
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rsicle s cert direct	To Be	eyaminer?	lospital: 1 / Inpatient 2	ER/Outpatient	3 DOA O	thos		sidenca 6 □Oth	ner (Specify)
g Phy g Phy gerthi neral	ii.	27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj			e how injury occur	
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Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Certification:		sician: To the best of my kn ner: On the basis of examin end manner steted.						
within To the Comp	ž	29b. Signeture end title of cartifies			29c. Licer	se number			ed (Month, Dey, Year)
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State		31. Date filed (Month, Day, Year)	32. Registrar's Sign		1	./ ,			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARY M. WERNER APRIL 1, 12:00 P.M 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL 110 GREENWAY, N.E. GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 29, 1918 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Hours MISSOURI 479-16-3211 80 Director Usual Residenca of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits GLEN BURNIE MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Na 23a or UNITED STATES 21061 110 GREENWAY, N.E. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 △ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: WW II à 3 Ø Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72: Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING ASSEMBLY WORKER Baltimore, Maryland 17 Father's Name (First Middle Last 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be till timent of Health and Mental H tants. If there 27 is marked oth jury or other traumetic even Be MARGARET E. KILL JAMES M. DANNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 57 BREMER DRIVE, GLEN BURNIE, MARYLAND 21061 PRISCILLA WERNER/ DAU. IN LAW 20a. Method of Disposition 20b. Place of Disposition (Name of Date APRIL 20c. Location - City or Town, State 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PK. 1999 4 □ Donation 5 □ Other (Specify) 21 Signath n of Funeral Service Licenspe 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examine Due to (or as a consequence of): Physician/Medical Examiner lician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician the Due to (or as e consequence of): for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 s 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After ! 1 Natural Division or Attending 5 Pending Investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

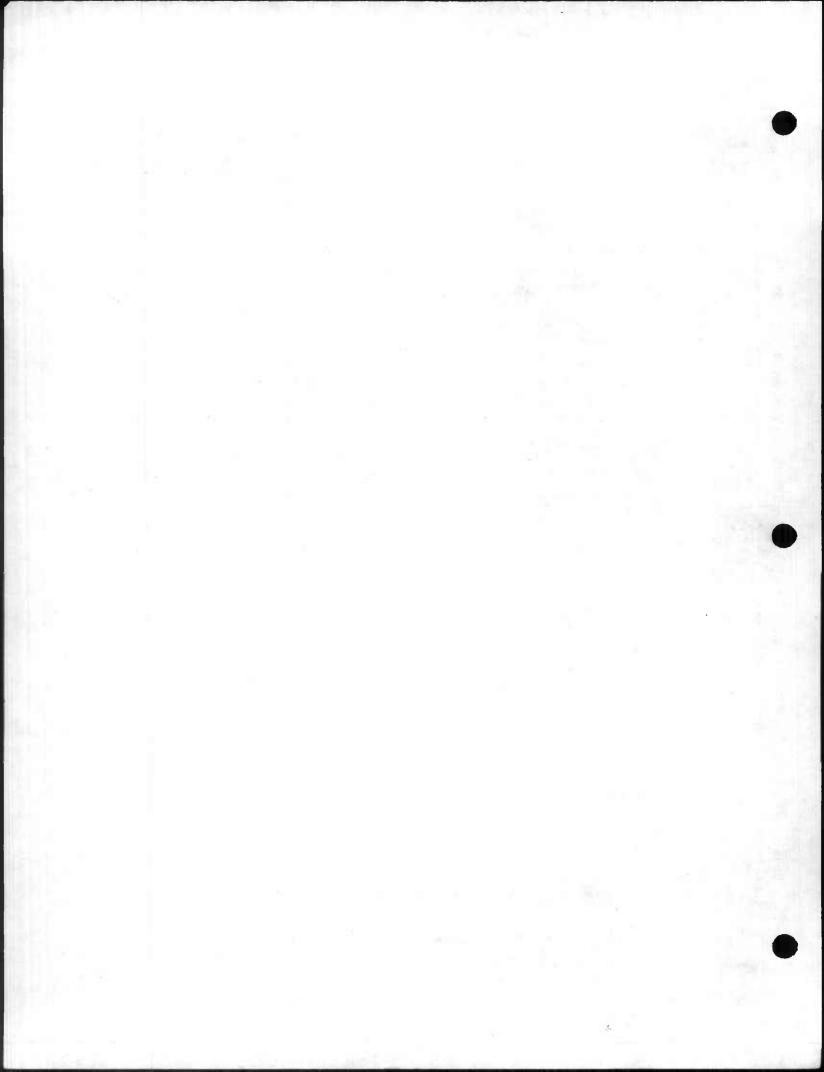
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the state 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) APRIL 2, 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) LASHMIPATHY SEENIVASAN, M.D., 606 HAMMONDS LANE, BALTIMORE, MARYLAND 21225

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)





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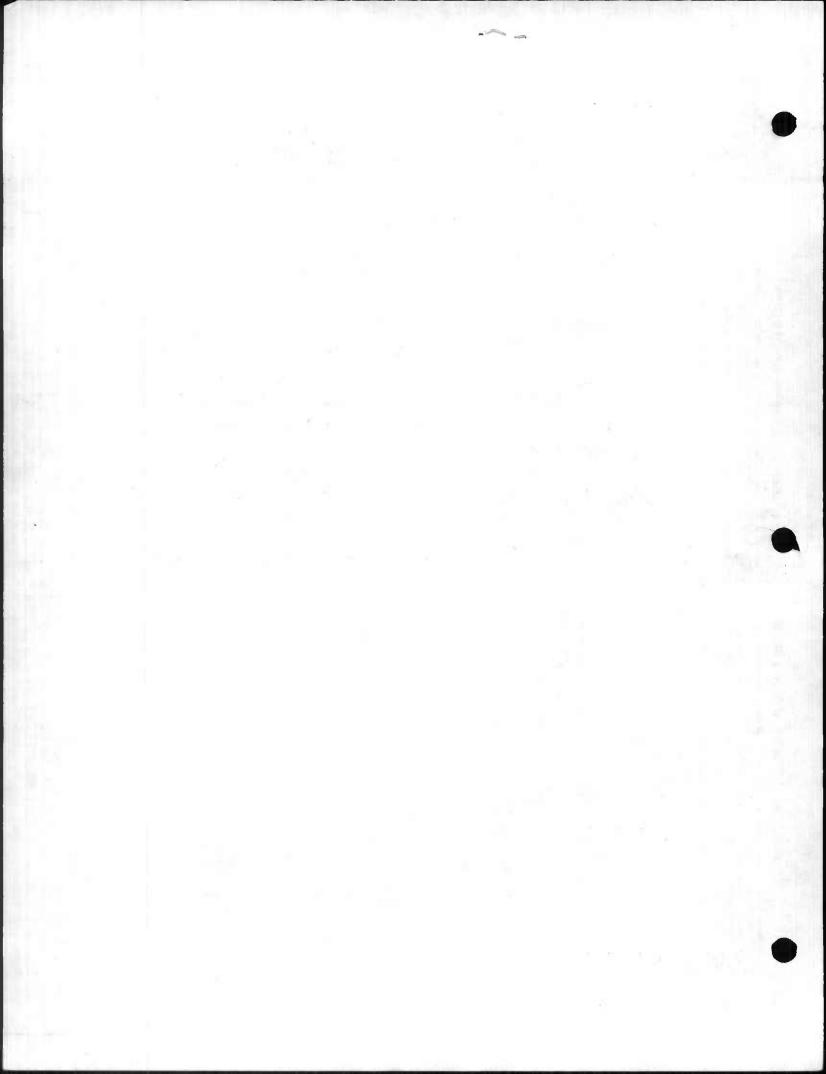
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Examiner	4a Facility Nama (If not institution,		0-		4b. City, Town, or Lo		4c. County		
	HBERTY	MEDICA		non	BALTIMOR			THING	ary
neral ector	5. Sociel Security Number 6 220-07-5689 Usual Rasidence of Dacedant	AMIN OF F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth Month, Day MAY 6,	1915	9. Birthplace (S	state or Foreign
	10e. State 10b. County		10c. City, Town o	Location				10d. Ins	ide City Limits
a or 28a-f show be notified at Director	MD.		BALTIMO	DE				1 12	Yes 2 No
Directo	10e. Street and Number	1	l0g. Citizen of V	itizen of What Country?					
	3804 WOODBINE	21207			U.S.A				
Funeral	3804 WOODBINE 11. Merital Stetus	12. Was Decedant E	as Decedant Evar in U.S. 13. Was Decedent of Hispanic Origin? (Sc			city Yes or No-	14. Rac	e - American Indi	an,
and sectial riggere. Is marked other than "natural", or its summitic event, the Medical Examine To Be Completed by Fur	1 Nevar Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:	0	1 ☐ Yes 2 ☒ No	Specify:	Hican, atc.)	Specify	k, Whita, atc.	
	15. Decedant's	Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Bu	siness/Industry	STORE OF
	(Specify only highest (Elementery/Secondery (0-12)	Collega (1-4or 5-	(Give kind of work done during most of work life. DO NOT use retired)						
	12		L	ONGSHOREMA	N		STEEL		
	17. Fether's Nama (First, Middle, La HORACE WILL				18. Mother's Nama SUZIE W	-	Maiden Sumam	(0)	
	19a, Informant's Neme/Relationship	a, Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number						State, Zip Code)	
	JAMIE WILLIAMS		380	4 WOODBINE	AVE. BAL	TIMORE	MARYLAN	D 21207	
	20a. Mathod of Disposition		20b. Place of Di	sposition (Name of crematory or other place				City or Town, St	ata
	1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		ARRITI	S CEMETERY	4	-1-99	ARBUTUS	MD.	
	21. Signatura of Funaral Sarvice Lic	ensee	ANDUIC	22. Nama and Addre					ME P.A.
	De 19	TAW PLACE							
	23a. Part1. Entar the disaase, or co shock, or haard failura. List on Immediate Cause (Finel disaasa or condition resulting In daath)	Interv	orimata al Between and Death						
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-	FUNGEMIA.					24a. Was a	n autopsy med?	24b. Ware aut aveilable completic of death?	prior to on of cause
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	25. Was casa rafarred to medical				26. Placa of Death				
	axaminar? 1 ☐ Yas 2 ☐ Mo	Hospital: Inpatier	t 2 ER/Outpe	itient 3 DOA Oth				er (Soecity)	
	27. Mannar of Death 1 Netural 5 Pending 2 Accidant investiget	28a. Dete of Injun (Month, Day	/ 28b. Tim	e of 28c. injur		28d. Describe h	-		- 7
Certification:	3 Suicide 6 Could not be detarmined 6 Homicida 6 Could not be detarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
edicai C	29a. Cartifier (Check only one) 12 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and mennar state	examination and/o	eath occurred et the tir r investigation, in my o	ma, data end place, a ppinion, deeth occum	and due to the d ed at the time, o	ause(s) end me late and place,	enner as stated. and due to the co	1U50(S)
Me	29b. Signetura end titla of certifiar	1)	^	29c. Licens				d (Month, Day, Y	
		deplone	e W/	3	1905-	7	Mark	27	1990
	30. Name and address of person with	o complated causa of de	ath (Item 23a) (Tv	pe, Print)	1905-7 1BERTY				
	162	140 8-	Conne	n L	1BCRTY	USE	KCAL	CONT	30
tate	31. Dete filed (Month, Dáy, Year)	32 Registra	's Signatura	TO B					

State Registrar

APR 2 1999

32, Registrar's Signatura B. Sparks

DHMH 16 Rev 6/95



State Registrar

31. Dete filed (Month, Day, Year)

freaker

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Sporks

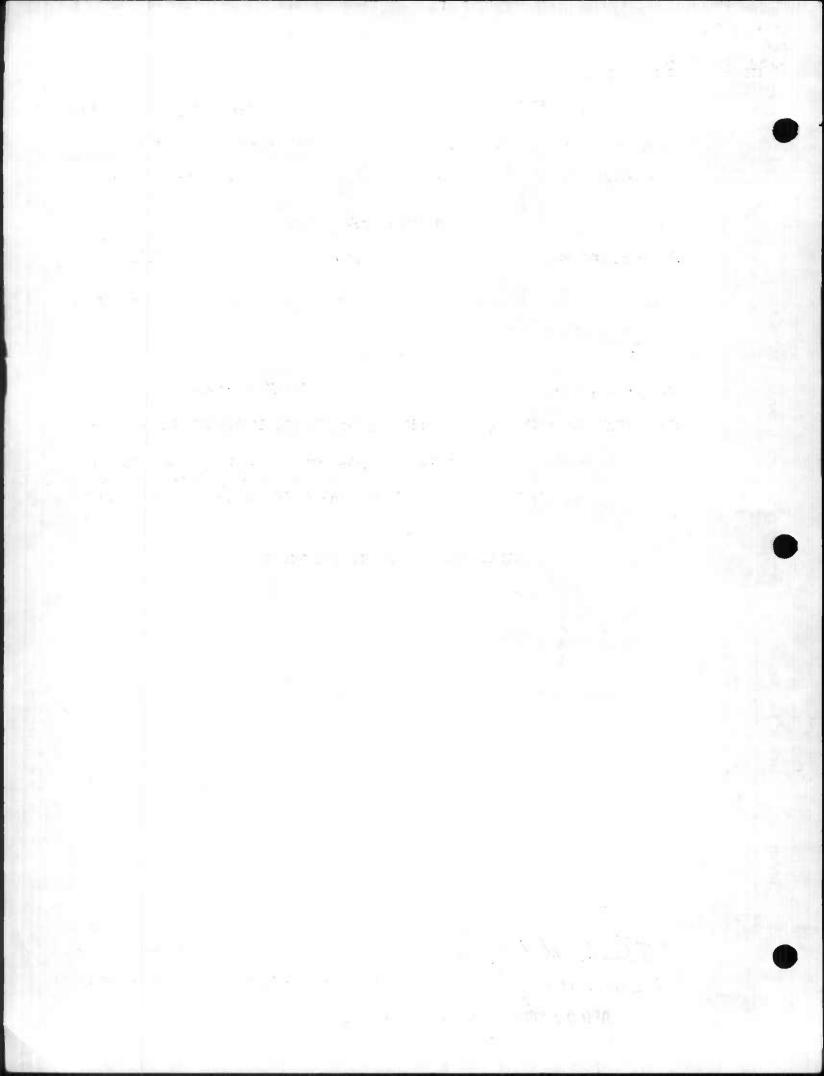
O.C.M.E.

March 24, 1999

111 Penn Street, Baltimore, Maryland 21201

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth **Physician** FARL WILKINS 3:40 AM 1999 MARCH /Medical 4a Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL, LOCHRAVEN 21239 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 6. Sex 1XXM 2□ F Birthplace (Stata or Foraign Country) **Funeral** 213-07-7010 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours eftar death with the Manylan Ih end Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modical Exemples motilled as 1 ☐ Yes 2 No Baltimore MD Bowleys Quaters Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 725 Seneca Gardens Road 21220 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 00 No If Yes, Give Year or Dates; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright Bethlehem Steel Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surnama) permit. Pages 1 end 2 should be Department of Health end Mental Important: If frem 27 is marked c any injury or other traumatic even page. Wilkins Herbert Rose Hissey 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Patricia A. Sullivan/daughter 5733 Arnhem Road Baltimore, Maryland 21206
Date 20c. Location - City or Town, State 20b. Place of Disposition (Nama of camatary, cramatory or othar place) 20a. Method of Disposition 1 Danation 2 □ Cremation 3 □ Removal from Stete 4 □ Donation 5 □ Other (Specify) Moreland Memmorial 04/03/1999 Parkville, Maryland 21. Signature duneral Service Licenses 22. Name end Address of Facility Stephen D. Coster Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. PartY. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical **Examiner** FAILURE Physician/Medical Examiner RENAL attanding physician end for use as the bunal-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or es a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown Mellitus py 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was en autopsy performed? Completed ANemir peen cartificata has b lirector, page 2 s 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours effar deeth.

To the Funeral Director: Affar this cartifica completaly filled in by the funeral director, it 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Streat end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. edicai 29a. Certifier

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) AJAY CHAWLA JAMBRI-1AW GWD

CHAWYA,

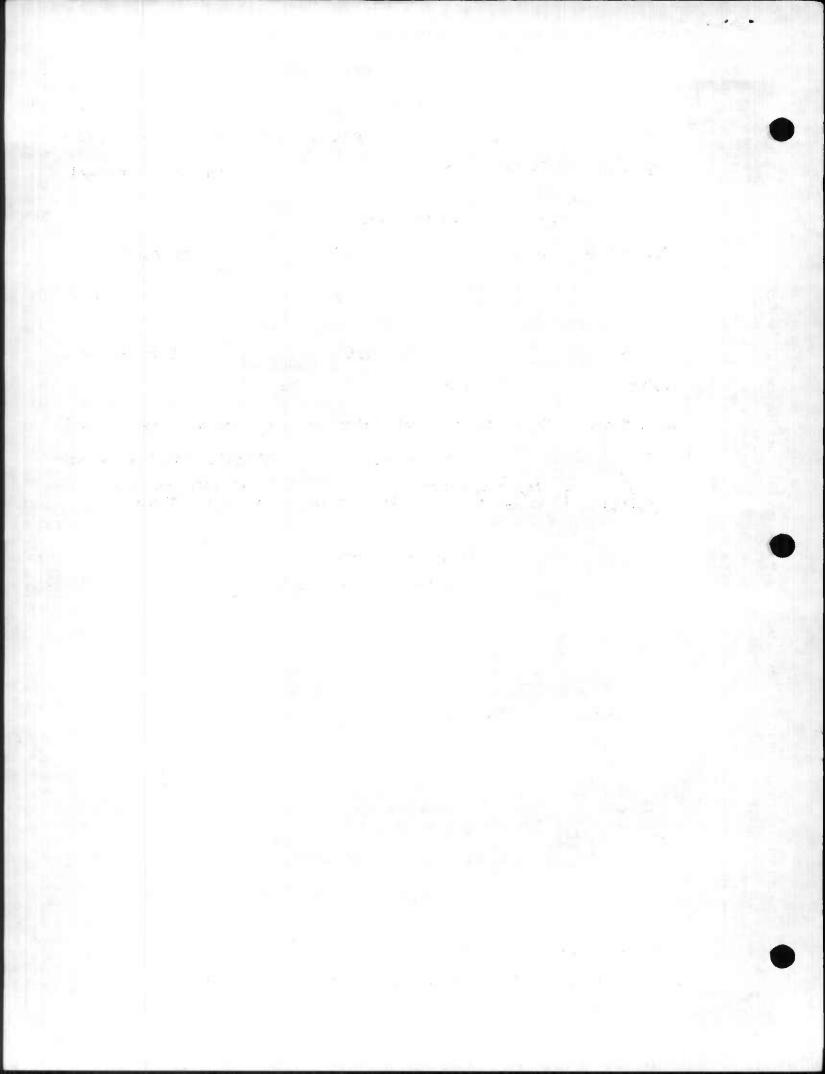
P-12556

29c. License number

29d. Date signed (Month, Dey, Year) MARCH, 31, 1999

HOSPITAL CALTIMORE MD 21228

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 28, Day 1999 **Physician** Sr. Eddie White 9:05am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Co. Fort Howard VA Hospital Fort Howard If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 1 1 M 2 □ F 9. Birthplece (State or Foreign **Funeral** Months Days Hours Yrs. 230-03-5864 81 Director N.Y. Usuel Residence of Decedent the Marylan r 28a-f show inotified at 10a State 10b County 10c. City. Town or Location 10d. inside City Limits 1 Yes 2 □ No Director Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be o U.S.A. 1102 Druid Hill Ave Apt 1013 21201 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1X Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 🏋 No Specify: Specify: Black by 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within sent of Health and Mental Hygiene. Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) E S Specialist Long Fence Sheet Metal 3rd grade other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be marked Theordosia Dickerson James I White 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ä Item 27 6 Mill Creek St, Owings Mills Md 21117 Edna Blackwell-Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State important: If its any injury or oth 2008 20a. Method of Disposition W Buriel 2 ☐ Cremation 3 ☐ Removal from State Baltimore Nat'l Cem. 4/2/99 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Advanced Stomach Cancer Unknown Examiner Due to (or as a consequenca of): Examiner Hypertension Unknown physicien and the burial-transit tha death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Angina Unknown Physician/Medical Due to (or as a consequence of): for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown The law requires thet þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? been si 24a. Was an autopsy performed? Completed certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death.

Funeral Director: After this certifical staly filled in by the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completaly filled in The company of the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. 29a. Certifier edical (Check only one) Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) end menner stated. 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 1)566

State 9 **DHMH 16 Rev 6/95**

Eddie

Box 68760

o

Division of Vital Records,

Registrar

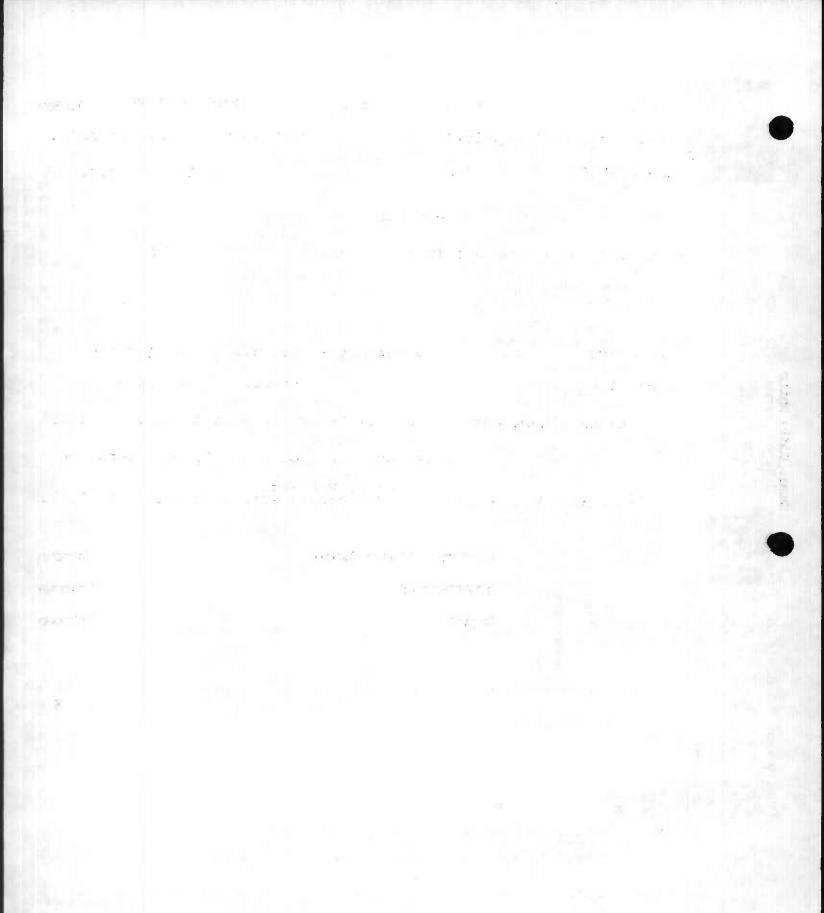
is of go

30. Name and e

who completed cause of death (Item 23a) (Type, Print)

Arastoo Yamani, MD 9600 North Point Road, Fort Howard, MD 21052

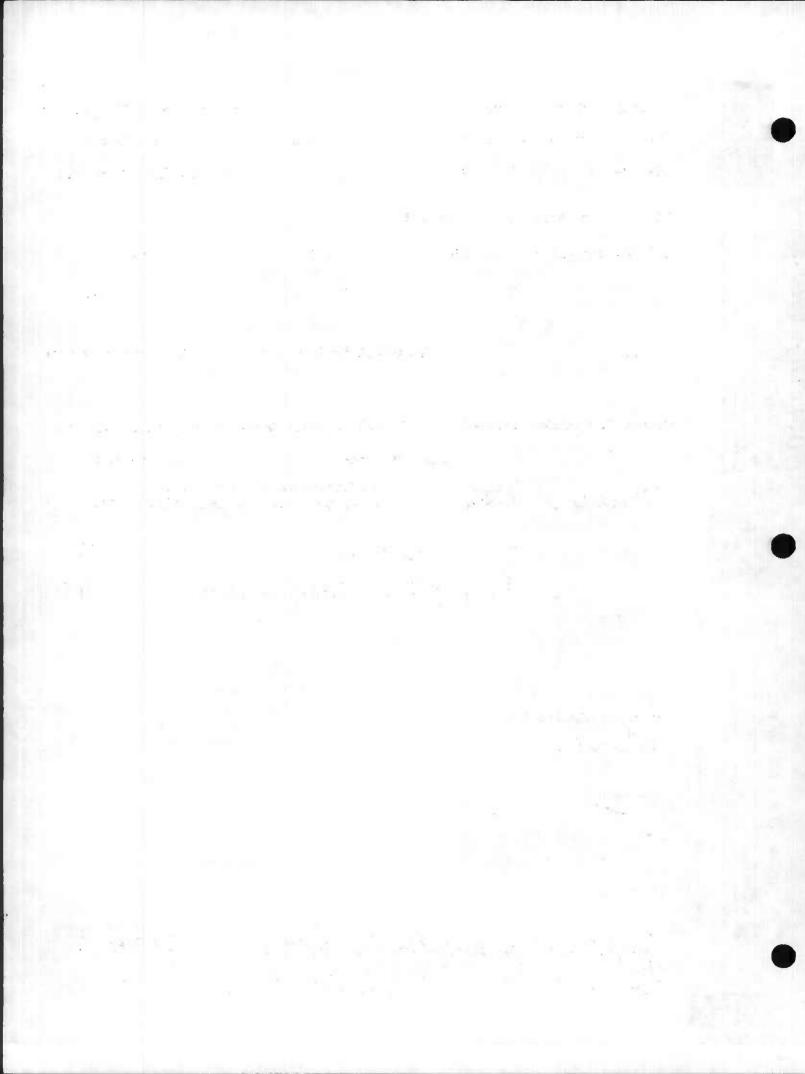
32. Registrar's Signature



	Decedent's Nama (First, Middla, Last)	Cer	tificate of	Dealli	2. Data of Dec	Reg. No.	1	3. Tima of Death
Physician /Medical	Dorothy Catherine Wiebe				Month	Day 26	Yaar 1999	5:25 am
Examiner	4a Facility Nama (If not institution, give street and number)			4b. City, Town, or L		4c. County	of Death	
	Anne Arundel Medical Cent 5. Social Sacurity Number 6. Sex 7. Agr	er a (In yrs. last birthday)	If Undar 1 Yaar	Annapoli If Under 24 Hrs.	8 Date of Birt	h	Arund	
Funeral Director	399–18–5193 ¹□ M 2⁄√F	74 Yrs.	Months Days	Hours Min.	Oct. 1	y, Year)	Wisco	aca (Stata or Foreign ny) Onsin
pue Ma	Usual Rasidance of Dacedant 10a. Stata 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
the Marylen 28a-f show notified at	MD Anne Arundel	Arnold						1 ☐ Yas XXNo
vith the Mai t or 28=1 s be notified	10e. Street and Number		10f. Zip Coda			10g. Citizan of	What Count	ry?
23a villa	622 Oakland Hills Drive,			012		USZ		
21215-0020 d within 72 hours efter death with the Maryland glane. r than "naturel", or frems 23s or 28s-f show it a Medical Examiner must be nutified at completed by Funeral Director	11. Marital Status 1 □ Nevar Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forcas? 1 □ Yas 3 □ Yas Yas or Datas:	No.	Vas Decedant of I Yas, specify Cub	Hispanic Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)	Specify	e - Amarica ck, Whita, a /: Whi	tc.
1 21215-002 ed within 72 hours ygiana. er than "naturel; ht, the Modical Ext	15. Decedant's Education (Spacify only highest grade completed)	16a. Deced	ent's Usual Occup	pation during most of work	kina	16b. Kind of B	usinass/Indi	ustry
2121 d within giana. r than r than	Elamentary/Secondary (0-12) Collaga (1-4or 5	ifa. L	OO NOT usa ratire	ed)		Amorrica	an IInd	annual to
of filed within other than other than vent, tre Mo	12 17. Fathar's Nama (First, Middla, Last)	M22121	ant to 1	18. Mothar's Nam	na (First, Middla.			versity
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Maryland 12 should be f is marked of reumatic eve To Be	19a. Informant's Name/Ralationship (Type, Print)	19b. Mailin	g Addrass (Straa	t and Number or Ru	rai Route Numbe	er, City or Town,	Stata, Zip	Code)
CENA	George J. Rykoskey (Friend		akland I	Hills Dri	ve, #10	1, Arnol	Ld, MI	21012
0 00 2 5	20a. Method of Disposition 1 ☐ Burial 2 MCramation 3 ☐ Ramoval from Stata	20b. Place of Dispo cemetary, cran	sition (Nama of natory or othar pla	ice)	Data 03/30	20c. Location -	City or Tov	vn, Stata
E 2667	4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	-		00,00	Baltimo	ore, M	D
Department of the same in the	21. Signatura of Funeral Sarvice Licansaa			y Funeral				
NAME OF TAXABLE PARTY.	23a Part 1 Enter the disease or complications that caused	tha death. Do not anti-	12 Ridge	ely Avenue	e, Annar	polis, N		IO1 Approximata
Physician	23a. Part1. Entar tha disaasa, or complications that caused shock, or heart feilure. List only one cause on eech lir	ne.						Intarval Batween Onsat and Death
/Medical	Immediata Causa (Final disaasa or condition a. Rein &	1 Fai	uve					Yrs
Examiner	rasulting in daath) a.	Dua to (or as a conseq	uance of):	,				. 1
od sit	- Nolu	1 CM STIC	Kid	noy di	serse		1	YLL
be executed ician and buriel-transit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to for as a conseq	uance of):				1	
5 5 5 C	triat irritiated avants	Dua to (or as a conseq	uance of):				1	
ng physicate as the Medicate	rasulting in deeth) Last						1	
The law requires that the death certific cate has been signed by the ettending p page 2 should be detached for use as Completed by Physician/Me	d			-			1	
s, F.O. Distribution as that the death gened by the ette be detached for by Physicia	Part II. Other significant conditions contributing to death be	ut not rasulting in tha u	ndarlying causa gi	ivan in Part I.	23b. Dld	tobacco usa co	ntribute to	the cause of death?
that that ed by the detache	Hypertansion				1 🗆	Yes 2□ No	3 ☐ Prob	ably 42 Onknown
ulias tha n signed alid be de	no T					an autopsy		re autopsy findings
w requires to be a second of the second of t	ne men) cu				perfo	ormad?	con	ilable prior to applation of causa leath?
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lcien: The lav certificate has rector, page 2	25. Wes case referred to medical			26. Placa of Dea				
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or Attending Physician: The law requires the flar creek. or Attending Physician: The law requires the flar creek. or Attending Physician: The law requires the flar this certificate has been signed in by the funeral director, page 2 should be cartification: To Be Completed by	27. Menner of Daeth 28a. Data of Inju (Month, Day	ry 28b. Time of Injury	28c. Inju		28d. Dascribe	how Injury occur	rred	
thendling deeth.	2 Accidant Invastigation	unu Athama farma]Yas 2□No	28f Loostine (Straat end Numi	her or Pusal	Route Number
tal or Attending P rs eftar deeth. al Director: After ti led in by the funera Certification:	4 Homlcida datarminad 28a. Place of Injudicing, atc	ury - At home, ferm, str c. <i>(Spacify)</i>	et, ractory, offica		City or To	wn, Steta)	oer or Mural	HOUR NUMBER
C esse	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred et the ti	ime, dete end piace	, and due to tha	causa(s) and m	annar es ste	eted.
n 24 hour na Eurai Pletaly fil	(Check only one) 2 Medical Examiner: On the bests of and manner sta	axamination and/or inv	astigation, in my	opinion, deeth occu	rred et the time,	date end plece,	and due to	the cause(s)
To the comp	29b. Signature and title of certifier	1/0	29c. Lican	sa numbar		29d. Data signa	d (Month, L	Dey, Year)
	your I true for Me	februl tru	days &	111965		5/2	-6/9	9
	30. Name and address of person who completed causa of d	laath (itam 23a) (Type,	Print) 14	A A.	1. 1.	/	1	
	31. Data filed (Month, Pay, Yaar) 32. Ragistri	ar's Signatura	ely Pl	7 DYII	1190111	s or	1 2	1901
State Registrar		ar s Signatura	hon V	1				

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Dorothy L. Wilson 30 10:10 pm 1999 March /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Daath **Examiner** 1175 Summit Drive Annapolis Anne Arundel If Under 24 Hrs. If Undar 1 Yaar Birthplace (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Days 1□ M 2√2 F Yrs 219-28-1911 67 July 20,1931 Director Maryland Usual Rasidance of Decedant with the Marylend 10d. Insida City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yas 2 No Director MD Anne Arundel Annapolis 10f. Zip Coda 10g, Citizan of What Country? 10e. Street and Number 1175 Summit Drive 21401 IISA Funeral 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Dacedant Evar in U,S. Armed Forcas? permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat page. 1 Navar Married 2 Married ☐ Yas 2 No Yes, Giva Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: White A 3 Widowad 4 Divorcad Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be William MacKenzie Elizabeth Tuder 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert F. Wilson (Husband) 1175 Summit Drive, Annapolis, MD 21401 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location · City or Town, State 20a. Mathod of Disposition Date 1X Burial 2 Cremation 3 Ramoval from State Hillcrest Cemetery 04/02 4 ☐ Donation 5 ☐ Othar (Specify) Annapolis, MD 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica License Hardesty Funeral Home, P.A. ulla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immadiata Causa (Final mar disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner the death certificate be executed physician and s the buriel-trans Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in death) Last Dua to (or as a consaquanca of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of): 98 esn signed by the e 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2□ No 3□ Probably 4□ Unknown Division of Vital Records, þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed been complation of cause of deeth? Hes 1 Yas ZONO 1 ☐ Yas 2 ☐ No certificate funeral director. 25. Was casa referred to medical axaminar? Be 26. Place of Daath (Chack only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Yaar) 27. Manner of Death 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After or Attending 1/Natural 5 Panding efter death.

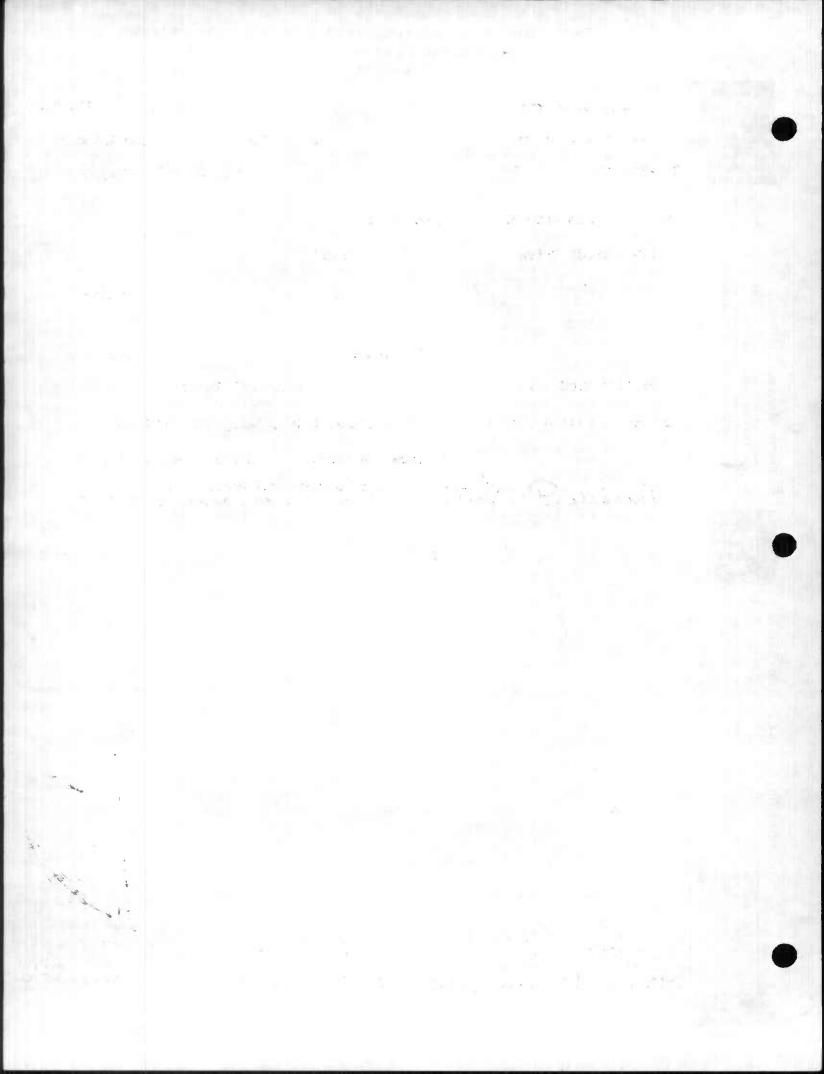
Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not ba 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) 3 4 Homlcide Hospital 24 hours edicai 29a. Cartifian TC critifying Physician: To the best of my knowledge, daath occurred at tha tima, date and placa, and dua to the causa(s) and mannar es stetad. completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the I within 2 To the § 29d. Dale signed (Mghth, Day, Year) 29b. Signatura and Manager of cartifian DYIC 30. Name and acdress of purson who complated cause of deeth (Item 23a) (Type, Print) 900 Brotapte Rol Ste 30 Ampulismo Stanley hatkins

State Registrar 31. Data filad (Month, Day, Yaar)

32. Registrar's Signatura

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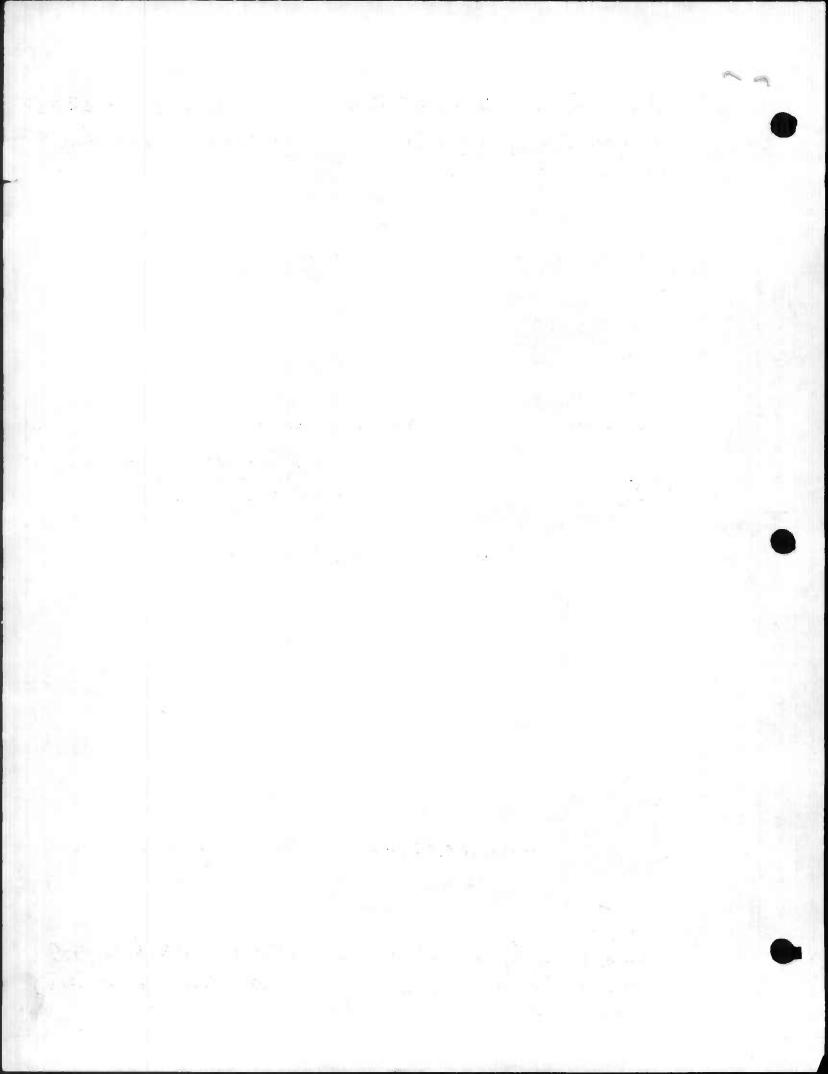
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0686 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** MARCH 20 K 004 /Medical on of Death 4b. City, Town, or Loc 4a Facility Name (If not institution, giva street and number) Examiner WAShy ton Coarty 9. Birthplace (Stete or Foreign Country) to 07 If Undaz 24 Hrs. If Under 1 Yo Months De 8. Date of Birth (Month, Day, Y Oct. 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 11MM 2□ F 21 148-66-9424 New Jersey Director Usual Residence of Decedent the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Medical Examinar must be notified at page. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39-B W. Salisbury Street Funeral 21795 S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Welder Crane Mfg. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Andrew Theodore Albertson, Sr. Esther Ruth Luber 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Robinson - Mother 39-A W. Salisbury Street Williamsport, Md. 21795 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/16/99 Hagerstown, Maryland Hagerstown Crematory 22. Nama and Address of Facility Minnich Funeral Home 21. Signeture of Euneral Service Licenses 15 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Way Examiner Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be execu Box 68760 Physician/Medical Due to (or as e consequence of). P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy lindings available prior to pege 2 should Completed 24a. Wes en eutopsy performed? completion of cause of death? has 1 Yes 2 No certificate 1 Yes 2 No Physician: 25. Was case referred to medicat Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2□ No 1 Inpatient 2VER/Outpatient 3□ DOA After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Netural 5 Pending investigation MARCH 15/99 0830 # Jelf INStructed 1 Yes 2 No Jun shot 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide MD. 21793 34-Bw. Salisbury Jome St. Williamsport edical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of a ortifie 29c. License number 29d. Data signed (Month, Day, Year) dause of death (Item 23a) (Type, Print) ME MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95



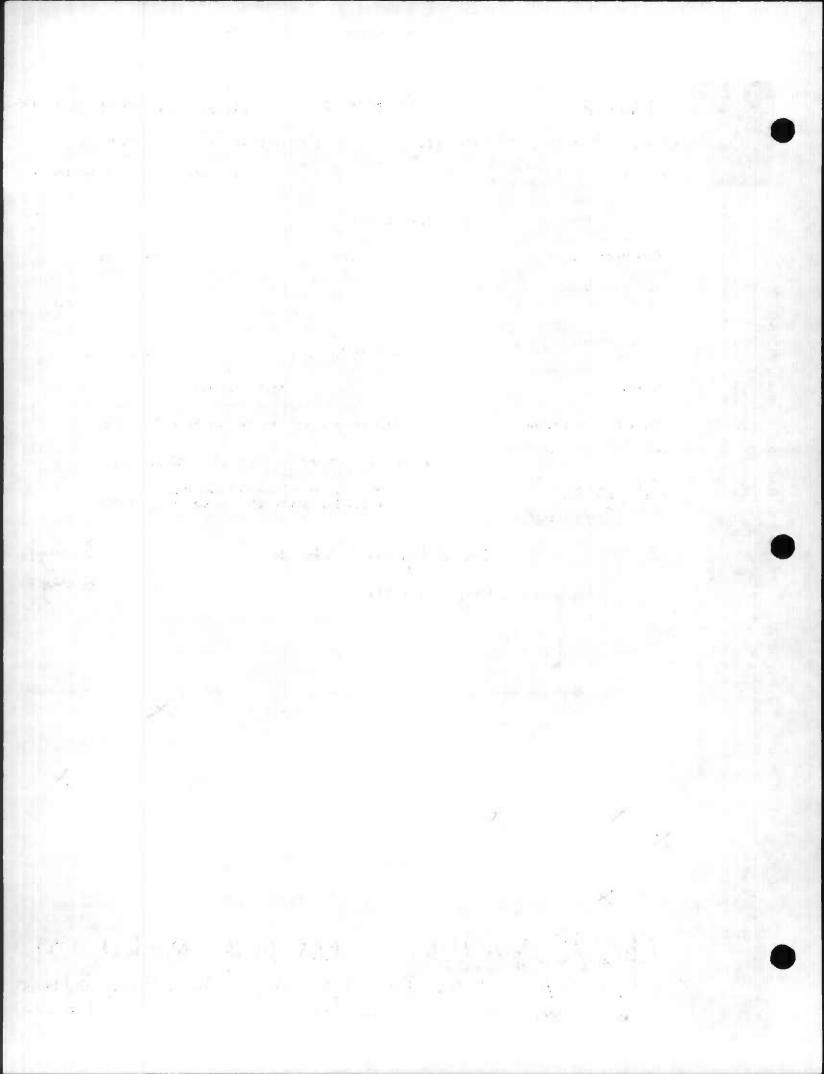
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ackerson 11: 10 AM 1999 larie TARCH /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner BALTIMORECIT HOPKINS HOSPITAL JOHNS Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Birthplaca (Steta or Foraign Country) **Funeral** Months Days 1□M 2ØF Hours 70 2/4/1929 Pennsylvania Director 181-24-3357 Usual Residence of Decedent the Menylend 10c. City, Town or Location 10a. Stata 10d Inside Clty Limits 10b. County 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director Franklin Favetteville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 6371 Ninth View Drive United States Funerai deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "natural", or han any injury or other traumate. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Building Secretary** School District 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Warren Creitz Lillian Silfies 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas C. Ackerson Fayetteville, PA 17222 6371 Ninth View Drive 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - Cltv or Town, State 1 Burial 2 □ Cremation 3 A Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towamensing Cemetery 3/23/99 Palmerton, PA 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee Thomas L. Geisel Funeral Home, Inc. 333 Falling Spring Road Chambersburg, PA 17201 En. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardiogenic da disaasa or condition resulting in death) Examiner Examiner myocarditis bunel-trensit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last De to (or es a consequence of): and physician Division of Vital Records. P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): 98 use Po 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause givan in Part I. signed by the 1 Yes No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen has page 2 1 ☐ Yes No certificate 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No invastigation ofter death 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 24 hours e Funeral I pellii Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edicai To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) cause of death (Item 23a) (Type, Print) Pohns Hopkins Hospital 31. Date filed (Month, Day, Year)

32. Hegistrar's Signature

MAR 2 2 1999



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3 Tables Sh

Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month char Jernon arch 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys Months 1₹0 M 2□ F 52 219-44-3464 June 18, 1946 Maryland Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Keedysville 1 ☐ Yes 2 ☑No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4834 Mt. Briar Road 21756 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 🖾 Yes 2 🔲 No It Yes, Give 1966-1968 Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Morital Statue 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ₺ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) 0 - 12laborer cable installation 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Richard Vernon Barger, Sr. Edith Eleanor Miller 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Emma J. Snavely/sister 4834 Mt. Briar Road, Keedysville, Maryland 21756 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State March 1 ☐ Buriet 2 ☑ Cremation 3 ☐ Removet from Stete 15,1999 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pairt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heen failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final diseese or condition resulting in deeth) Sequentielly tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Abuse 20 Due to (or es e consequence of):

Physician /Medical Examiner

reportant: If Item 27 any injury or other to

Physician

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Examiner

Director

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filed within 72 hours after

Pages 1 and 2 should be Health and Mental

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical Medical Certification: To Be Completed by

this 24 hours after deat Funeral Director: completely filled in by

Division of Vital Records, P.O. Box 68760,

Barger

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State Registrar

31. Dete filed (Month, Dey, Year)

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29b. Signaturii

120/N-MD 32. Redistrer's Signeture

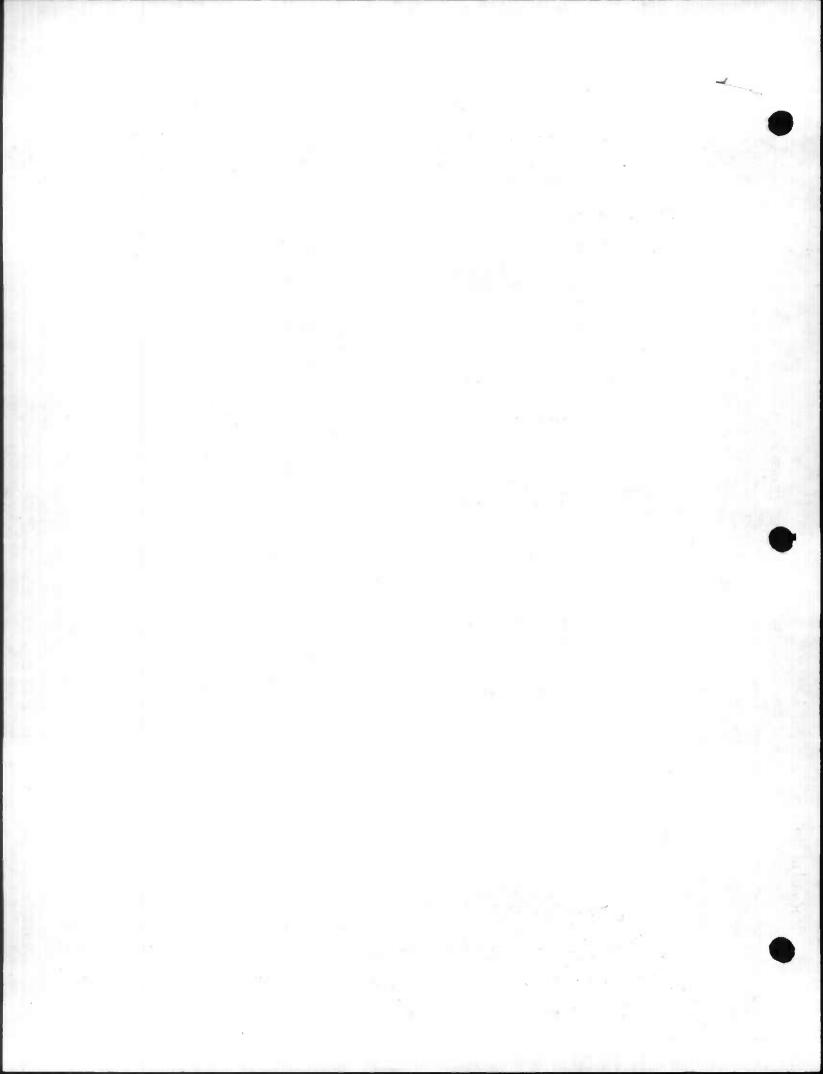
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

4236 MERODON VION DR HAGERSTOWN MI

29c. License number

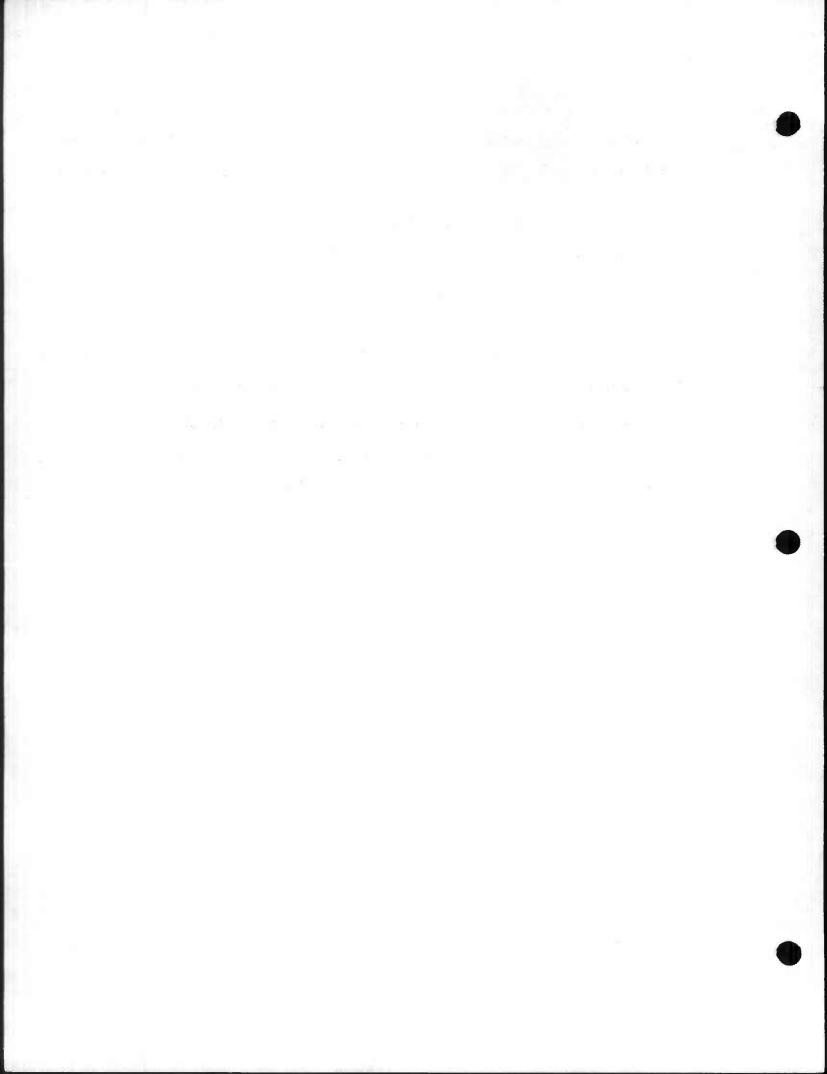
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

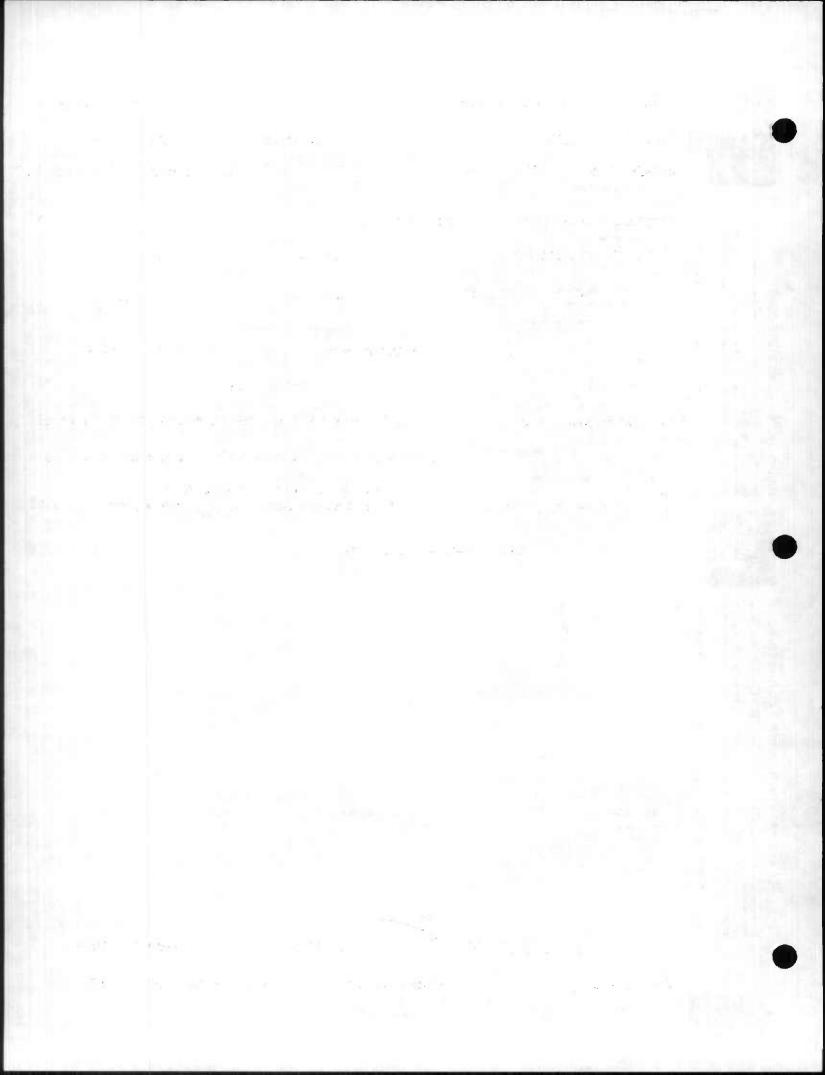
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-	Funeral		5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If U	Jnder 1 Yaar	If Under 24 Hrs. 8	Data of Birth	91	Birthplace (State or Foreign
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_6	ficete be executed physician end is the buriel-transit	Exar	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	a of):				
68760,	slciau slciau	dical	Cause (Disease or injury that initiated events	a of).				1
	ntificel ng phy as th	w	resulting In death) Last	2 017.				
Вох	leath certific ettending p	lan/I	d	-				
0	The lew requires that tha death certifite has been signed by the ettending rage 2 should be detached for use as	Physiclan/M	Part II. Other significant conditions contributing to death but not resulting in the underly	/ing cause gi	ven in Part I.	23b. Dld to	obacco use contrib	ute to the cause of death?
0	as that tha de igned by the e be detached?		Peritaritis Anteron Merotic Cand	raan	anden	1 🗆 Y	es 2□No 3□	Probably 4 Unknown
rds,	luiras n sign	d by	Peritoritis Antero relevatic cond		Mea 15	24a. Was a		b. Were autopsy findings
Record	w require s been si	Completed	The purchase tage	the !		perfor	mad?	available prior to completion of cause of deeth?
	The lew ate has page 2	шо	Faither respection chance deline	en R	Imas	1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
Vital		Be C	25. Was casa referred to medical exeminer?		26. Piece of Death (Check only or	70)	
>	5 00	To	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3	□ DOA Ot	her: 4 Nursing Home	5 🗆 Reside	enca 6 Other (S	ipecify)
Division of	fter	on:	27. Menner of Death 1 Afterel 5 Pending 28a. Date of Injury 28b. Time of Injury Injury	28c. Inju Wo		d. Describe h	ow Injury occurred	
Si	deeth deeth stor: /	Certification:	2 Accident Invastigation 3 Suicide 6 Could not be determined 28e. Plece of Injury At home, farm, street, farmant street, farma		Yes 2 No	f Location (S	treet and Number or	Rural Route Number,
2	aftar aftar Direct	ertii	4 Homicide determined building, etc. (Specify)	actory, omce		City or Tow		Tibras Trobio Trainboi,
	To the Hospital or Attendi within 24 hours aftar deeth. To the Funeral Director: A complataly filled in by tha fi		29a. Certifier (Check only 2 Madical Examiner: On the basis of examinering and/or investig					
	the Ho lin 24 the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investige and menner stated.	ation, in my	opinion, death occurred	at the time, d	ate and place, and	due to the cause(s)
	To Too	Σ	29b. Signature and title of certifier	29c. Licen			e9d. Dete signed (M	
			100000		18015		March 15	.(775
			30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)	CI	11	. 1		
	Sta	te	31. Date filed (Month, Day, Yaar) 32. Registrar's Signatura	311	KAq.	n de		
	Registr		MAR 1 7 1999	door	6			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death March 14 **Physician** Robert Merritt 1999 Bugosh 9:50 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner 12021 Kemps Mill Road Williamsport Washington If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) May 27, 1943 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) **Funeral** 1**№**M 2□ F Months Days Hours Yrs. 228-58-7529 55 Washington D.C Director Usual Rasidance of Decadant deeth with the Marylend permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Mocical Examtiver must be notified an once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Directo Washington Williamsport 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 12021 Kemps Mill Road 21795 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Radio Station Sales Manager 12 18. Mother's Nama (First, Middla, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Be Emil Bugosh Helen Hreha 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Mary Ann Bugosh, Wife 12021 Kemps Mill Rd. Williamsport, Maryland 21795 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBuriai 2 Cramation 3 Ramoval from Stata Columbia Gardens March 18,1999 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Douglas A. Fiery Funeral Home 1 Secretary 1331 Eastern Blvd. N. Hagerstown, Maryland 21742
23a Part1. Enter the disease, of complications that debsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting In death) /Medical Glioblastoma Multiforme 3 months Examiner Due to (or es e consequance of) Examiner physician end the buriel-transit deeth certificate be executed Sequantially list conditions, if any, laading to Immadiate cause. Enter Underlying Causa (Disaasa or Injury Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical that initiated avants rasulting in daath) Last Dua to (or as a consequance of): USB 85 1 for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed peen complation of ceusa of deeth? certificate hes b lirector, page 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was casa rafarrad to medical axaminar? director 26. Place of Death (Check only one) Be To Othar: 4 ☐ Nursing Homa 5 🖾 Rasidance 6 ☐ Othar (Specify) 1 Yas 2ONo 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death Certification: After 5 Panding invastigation 1 XNatural sefter death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 6 4 Homicida 8 .5 filled Hospital 24 hours Funeral 1 Certifying Physicien: To the best of my knowledge, daath occurred at tha time, data and place, and dua to the cause(s) end mennar as stated.
2 Madicel Examiner: On the basis of axemination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian edicai within 24 hor To the Fune completely fi (Check only 29c. Licanse number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifian D 21470 March 16, 1999 o of wath (Itam 23a) (Type, Print) 30. Nama and addrass of person who complated 11110 Medical Campus Rd. Dan H. McDougal MD Hagerstown, Maryland 21742 31. Deta filed (Month, Day, Year) 32. Registrar's Signatura MAR 17

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0855 AM Lena Virginia Bowers March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown, Washington Washington County Hospital If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

July 24, 1918 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Months **Funeral** Days 1 □ M 2 1 F Yrs. 80 220-18-0896 Director Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Washington Clear Spring MD 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13408 Clear Spring Road 21722 U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☑No If Yes, Give white 1 ☐ Yes 2 No Specify: Specify: by 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ribbon MFG. Elementary/Secondary (0-12) College (1-4or 5+) Ribbon Technician 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health end Mentel Hant: If Item 27 is marked out Be Lottie L. Hart Lloyd W. Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health e. Important: If Item 27 is any injury or other trat once. Betty Jo Kriner 11232 Dam 5 Rd. Clear Spring, MD. 21722 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shanktown Cemetery Mar. 23, 1999 Big Pool, MD 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc. P.O.BOX 310 Clear Spring, MD 21722 23a. Pgf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner thet the death certificate be executed physician end the bunel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Physician/Medicai Due to (or as a consequence of): na ettending for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o. the 1 Yes 2 No 3 Probably 4 Unknown 6 signed t by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed peen has PH. 1 Yes 2 TNO 1 Yes 2 No certificate Division of Vital Physician: 25. Wes case referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: : After I Attending 1 Natural 5 Pending 1 Yes 2 No death. ne Hospital or Attendii n 24 hours efter death. ne Funeral Director: A 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier (Check only one) completely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies h.D. 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) HIGERSTONN MD 21740 MILL ST. 350 72AD C1560 1. ANDRADE

32. Registrar's Signature

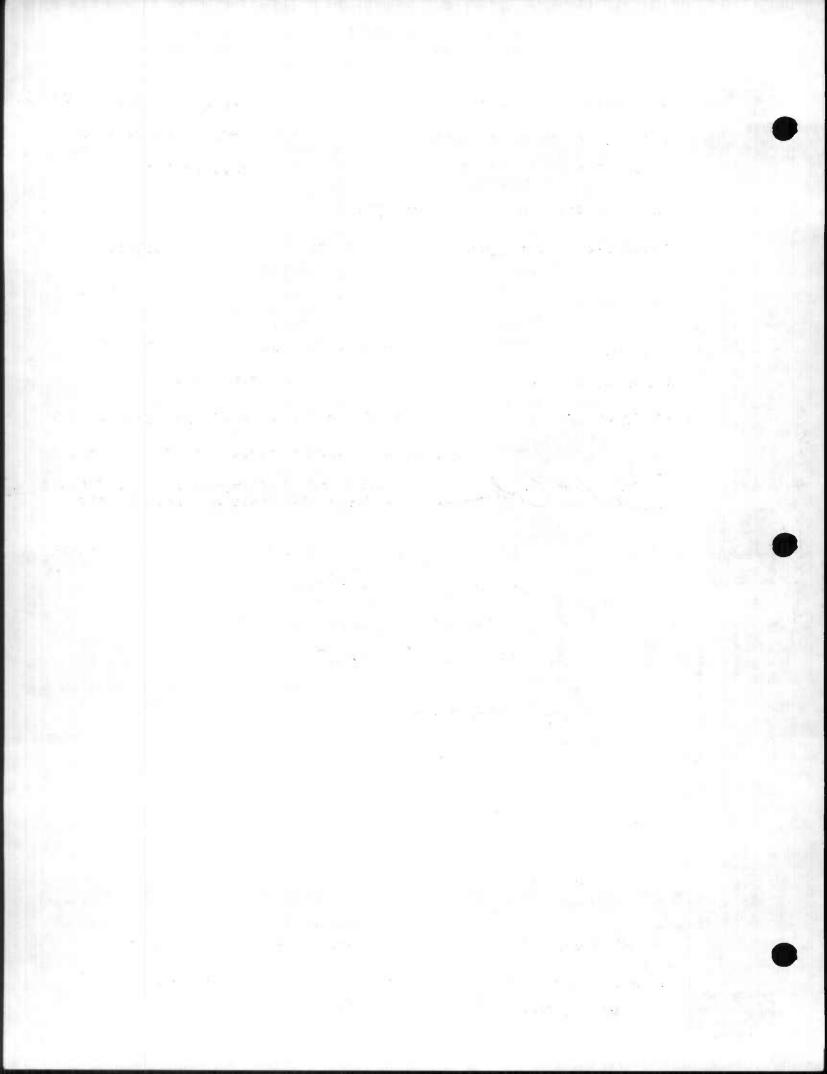
State

Registrar

31. Date filed (Month, Day, Year)

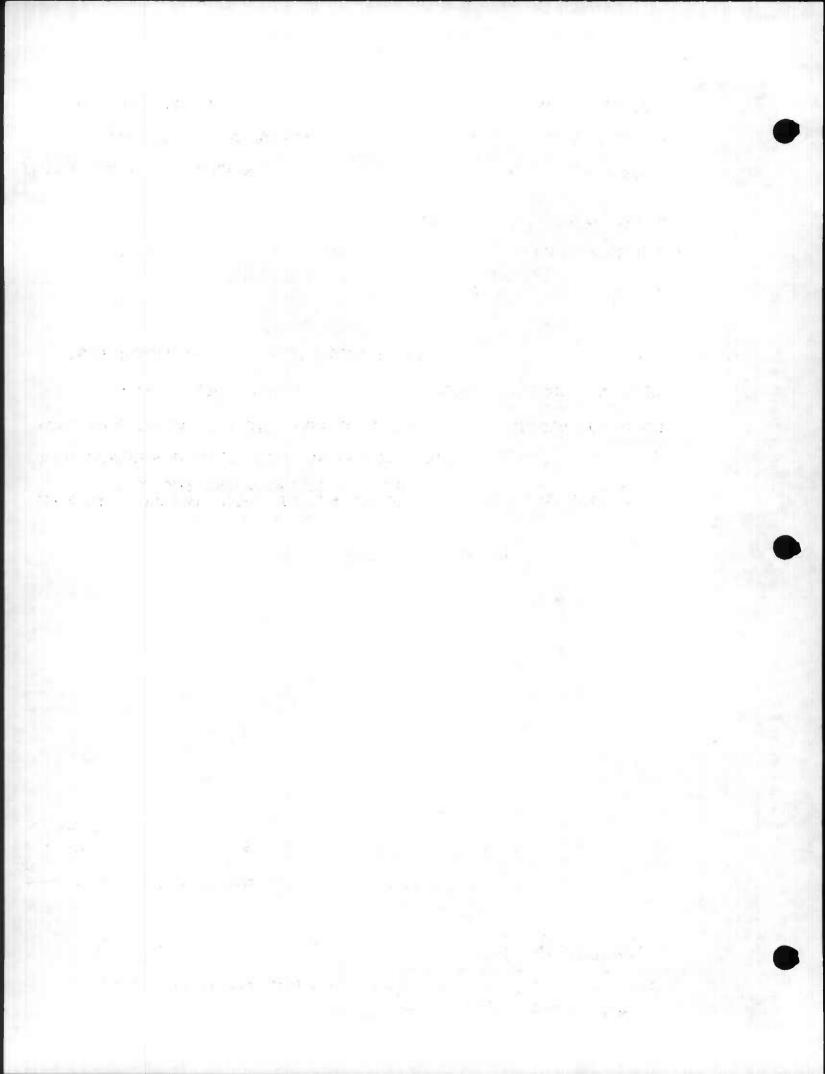
MAR 22

Virginia



State of Maryland / Department of Health and Mental Hygiene

A.	LESISH BA	GENT	State of Maryland		ficate of			eg. No.		0693	
ľ	Physician	Decedent's Name (First, Middle, Last) ALEISHA DIAN					2. Date of Dea Month MARCH		Year	3. Time of Deeth 2110 PM	
Ž.	* /Medical Examiner	4a Fecility Name (If not institution, give s WASHINGTON COUNT	treet end number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth		
400	Funeral Director	Social Security Number 6. Sex			If Under 1 Year Months Days	HAGERST If Under 24 Hrs. Hours Min.		WASH 1981	9. Birthp	OIN blace (State or Foreign "H" CAROLINA	
	TO .	Usuel Residence of Decedent 10e. Stete 10b. County		, Town or Loca	tion				1	0d. Inside City Limits	
	vith the Maryl t or 28a-f sho be northed a	MARYLAND WASHINGTON HAGERSTOWN								1 ☐ Yes 2 ☐ No	
	3a or 2	714 GEORGE STRE	ET		10f. Zip Code 21740)	1	U.S.		itry?	
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23s or 28s-1 show other traumetic event, the Medical Evanties must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	I2. Was Decedent Ever in U,\$ Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of Horses, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Ricen, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: WHITE				
15-0	"natural ages	15. Decedent's Educ (Specify only highest grede	cation completed)	(Give kir	nt's Usuel Occup nd of work done NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Ind	dustry	
212	be filed within 72 hor tal Hygiene. d other than "natura event, the Medical Be Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	SALES		CIATE	DEPARTMENT STORE				
land	should be fitted and Mental He marked oth umatic even	17. Fether's Neme (First, Middle, Last) WILLIAM JOS	EPH BAGEN	Т		18. Mother's Nam		Meiden Sumen BUR			
lary	2 should and Marianaria	19a. Informant's Name/Relationship (Type		T	Address (Street		rel Route Number, City or Town, Stete, Zip Co			Code)	
Page Page nent o int: if	LINDA SUE BAGENT 120 WOODSIDEAVENUE, GASTONI, NORTH CAROL 20e. Method of Disposition 20b. Place of Disposition (Name of cemelery, cremetery, cremetery) or other place) Date 20c. Location - City or chemetery, cremetery or other place)										
	4 Donetion 5 Other (Specify) CEDAR LAWN MEMORIAL PARK 03-17-99 HAGERSTOWN,										
Ball	pemit. Depertming of the properties of the prope	21. Signeture of Funeral Service License R. Koel	redy			SS of Facility COFFMAN F TIETAM ST				ND. 21740	
		23a. Pert1. Enter the disease, or complications, or heart failure. List only on	cation that caused the death e ceuse on each line.							Approximate Intervel Between Onset end Death	
	Physician /Medical Examiner	Immediate Ceuse (Final diseese or condition	Munnes	DWW	nios						
		Due to (or es e consequence of):									
	icate be executed physicien end s the buriel-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	Due to (or	es e conseque	ence of):						
68760,	ficate be executed physicien end street transit set the buriel-transit edical Examir	ceusé. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of):									
_		desuiting in deetin) Lest									
Box.	net the death cert d by the ettending leteched for use of Physician/M	Part II. Other eignificent conditions con	tributing to death but not resu	ven in Pert I.	23b. Did tobecco use contribute to the ceuse of deeth?						
р.	thet the ned by the detech			1 Yes 2 10 3 Probably 4 Unknown							
Division of Vital Records, P.O.	The lew requires that the death centrate has been signed by the ettending page 2 should be deteched for use Completed by Physician/M						24a. Wes e	4a. Wes en eutopsy performed?		ere eutopsy findings eilable prior to empletion of ceuse death?	
al R	The page						1994		1 (Types 2 No	
<u> </u>	hysiclan his certifi il director	25. Wes cese referred to medical examiner? 12 Yes 2 No	ospital: 1 ☐ Inpatient 🐰	ER/Outpetient	3□ DOA Oti	26. Plece of Dee her: 4 Nursing He	th <i>(Check only or</i> ome 5 Resid		er (Specia	fy)	
0 0	fer this neral di	27. Menner of Deeth 1 □ Natural 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. fnju Wo		28d. Describe h		-	SNOTHER CADA	
/isio	tal or Attending Physician: rs efter death. el Director: After this certification by the funeral director, Certification: To Be (2 Accident investigation 3 Suicide 6 Could not be determined	3 12 94 28e. Plece of Injury - At ho	To 301		Yes 2 No	28f. Location (S	treet and Numb		al Route Number,	
ă	ital or A irs efter el Direc lled in by	4 Homicide	building, etc. (Specify				FRONKUN -	t WINTY	ST, WA	Whiym 6	
	To the Hospital within 24 hours of the Funerel completely filled	29a. Certifier (Check only one) 1☐ Certifying Phys Wedical Exemin	icien: To the best of my know er: On the besis of examineti end menner stated.	viedge, death o ion end/or inve	stigation, in my	me, dete end plece, opinion, deeth occur	end due to the c red et the time, c	euse(s) end me dete end place,	end due t	teted. o the ceuse(s)	
	withir To th	29b. Signeture end title of certifier	DM . Das		29c. Licens	se number •M•E	-	29d. Dete signe MARCH			
		30. Neme end eddres of person who co					- (1)				
	Chaha	31. Dete filed (Month, Day, Year)	32. Registrar's Signat			t, Baltim	ore, Mar	ryland :	21201		
	State Registrar	MAR 1 6 199	9	D.	poork	2					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Dey Month Year **Physician** DORIS MARGARET BYERS MARCH 10, 1999 0134 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Dete of Birth Month, Dey, Yeer) MAY 22, 19 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (Stata or Foreign Country) WEST VIRGINIA 5. Sociel Security Number **Funeral** Days T VIRGINIA 1 □ M 2 🖾 F 79 Yrs. 1919 Director 203-10-7922 Usual Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Director MARYLAND WASHINGTON HAGERSTOWN 28a-1 10e Street and Number 10f Zio Code 10g. Citizen of Whet Country? 8 21740 711 SALEM AVENUE Berns 23a U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Year or Detas Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 9 YEARS INSPECTOR ELECTRONICS MFG 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be III mant of Health and Mental H ant: If Item 27 is marked off 88 JAMES F. ASHBY ELSTON F. WHITACRE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Important: If Item 27 is any injury or other tra-once. RALPH S. BYERS, HUSBAND 711 SALEM AVENUE, HAGERSTOWN, MARYLAND 21740 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State BOONSBORO CEMETERY 03/11/1999 4 ☐ Donetion 5 ☐ Other (Specify) BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility . 87 Dr. 7606 OLD NATIONAL PIKE P. STEVEN DANFELT, JR. BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final 4 WKG neumonia diseasa or condition resulting in daeth) Examine Examiner Hon Inknown physician and the burial-transit Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Ceuse (Disaesa or injury that initiated events rasulting in death) Last Due to/(or es a consequence of): Dementia Physician/Medical 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Galetise mellifus 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy lindings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No t ☐ Yas 2 ☐ No Vital 25. Was casa referred to medical axeminer? Be 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Sunpatient 2 □ ER/Outpatient 3 □ DOA of 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 1 SNaturei 5 Pending n 24 hours after death.

No Funeral Director: After pletchy filled in by the fur 1 Tyes 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 4 Homicide 5 Hospital edicai 29a. Certifier Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the besis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifier 29c. License number March 10, 1999 144996 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAPAR MBLIR 20 3// LAPPANS RODUSTORD MD 21713. 32. Registrar's Signetura 31. Dete filed (Month, Day, Year)

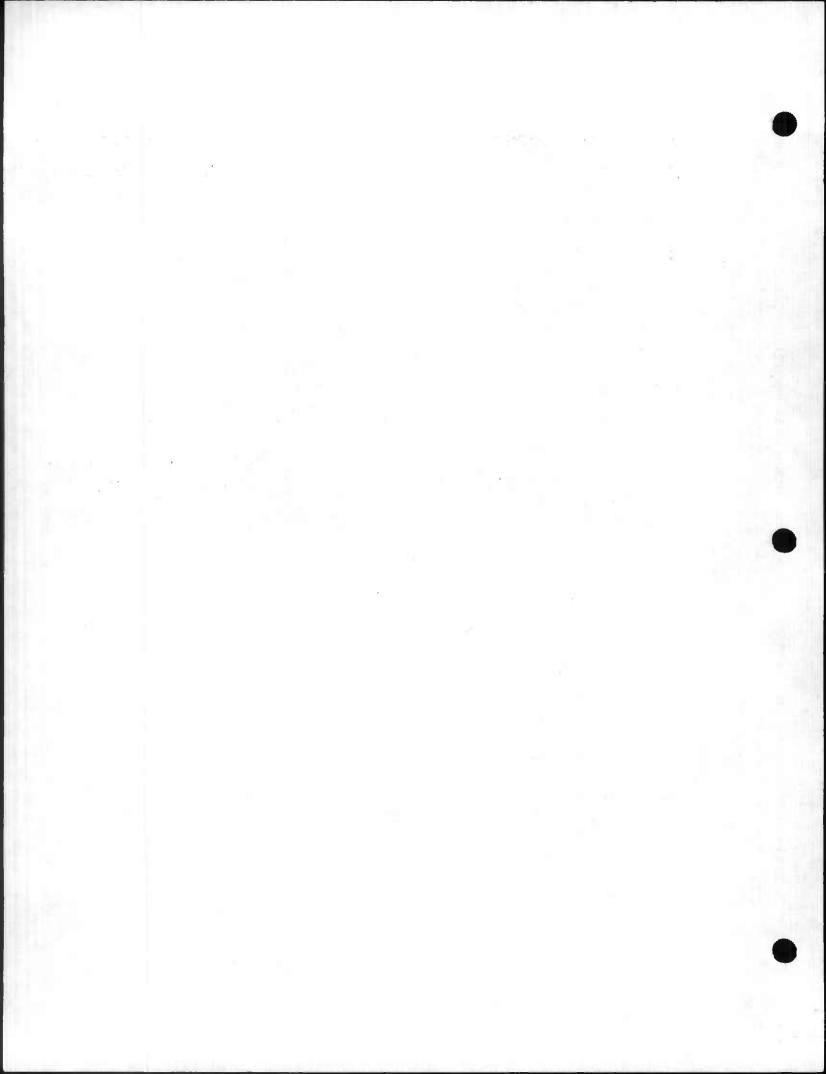
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State

Registrar

MAR 1 1 1999

MARGA RET



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	Pecedent's Name (First, Middle, L ROLLON OSC						2	Date of Death			O Time of Death	
/Medical Examiner 4a. F	ROLLON OSCA								Day	Year	3. Tima of Death	
Examino								Month 3	20 20	99	7:45 AM	
	Facility Name (If not institution, gi		nber)			-	wn, or Location		4c. County			
	13218 Rollie RD		`				opville			ester		
Director 5	502-16-5945	Sax 1X0 M 2□ F	7. Aga <i>(In yrs. I</i> a 76	st birthday) Yrs.	If Under 1 Yas Months Day		24 Hrs. 8. 1	Date of Birth (Month, Day, Ye /8/23	ear)	9. Birthpla Country	ca (Stata or Foraign V) ND	
Usua 10a.	al Residence of Decedent State 10b. County		10c. City.	Town or Lo	cation					100	d. Insida City Limits	
10a.	MD Worce	ester		ishop	ville			1 □ Yes 2 🗷 N				
from 23a or 28e-1s from 23a or 28e-1s from 23a or 28e-1s	. Street and Numbar 13218 Rollie RD)			10f. Zip Code 2 1	813		10g.	USA	tizen of What Country? USA		
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s-f show sheal Everyone treat or items be notified at 1 1 1 y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Marrial Status 1 Never Married	Armed For	12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates:			Hispanic Orly lban, Mexican o Specify:	gin? (Specify , Puerto Rica	acify Yas or No- Rican, etc.) 14. Race - American Black, Whita, at Specify: Wh			c.	
- c · #	15. Decedent's E (Specify only highast gr (lementary/Secondery (0-12)	ducation ade completed) College (1-	4or 5+)		ient's Usual Occ kind of work don DO NOT use reti		of working		o. Kind of Bu			
filed within Hygiens and Fre Man		5+		Nucle	ear Phys	T			US Go		nent	
To Be Committee of the control of th	Fathar's Name (First, Middle, Las Oscar Bondelid	1)						rst, Middle, Maid avelle	den Sumamı	e)		
	a. Informant's Name/Relationship Connie M. Bond		fe		g Address (Stre 8 Rollie						ode)	
0 - H 10 = 20a.	. Method of Disposition		state cer	matary, cran	sition (Name of natory or other p		1		. Location - (n, State	
altin arimen orients fejury	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Sur		lemorial			4/99 E	Berlin,	, MD		
Department of the service of the ser	Signature of Fune of Service Lice	Bulio.			. Nama and Add		Burl	bage Fu		Home	:	
Physician 23a	a Part Enter the disease, or con shock, or heart failure. List only			Do not ent	er the mode of d	ying, such as	cardiac or ra	spiratory arrast,		le le	Approximate ntarval Between Onset and Death	
dise	nediata Cause (Final ease or condition ulting In deeth)	ATTHE	MOSCLE	LOTIC	uence of):	DIOVAS	CULA	R DI	SEAS L	3		
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oertificate be assocuted ding physician and isa as the burial-transit areas the burial-transit integral Examine	quentially list conditions, ny, leading to immadiate se. Enter Underlying		Due to (or a	0				-				
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certificate be ding physicia as the bu	ulting in death) Lest		Due to (or a	as a consaq	uanca of):							
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Batto death	ii. Other significant conditions	contribution to dea	ath but not result	Ing in the ur	ndertylna cause (aiven in Part I	1	23h Did toher	CO Hee COD	tribute to t	he cause of death?	
P.O. do by the detachy he detach the								1 Yes	2 0 No	3 ☐ Probe		
aw requir				-				24a. Was an a performed	utopsy 1?	avail	a autopsy findings abla prior to pletion of cause ath?	
								1 🗆 Yas	211No	1 🗆 🕆	Yas 2 No	
f Vitai I yalclen: The yalclen:	Was case referred to medical axaminer?					26. Place	of Death (C/	heck only gne)				
- 5 00 D	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2 E	R/Outpatlen	t 3 DOA	ther: 4 Nu	rsing Home	5 Pesidence	a 6 Othe	r (Specify)		
ding him tion	Manper of Deeth 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident Investigation	28e. Dete of (Month)	f Injury , Day Year)	8b. Time of Injury	28c. Inj W	uryet ork? ⊒Yes 2 □ h		Describe how I	njury occurre	ed		
Division of Attending P as after death as a line tors. After ted in by the funer led in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	of Injury - At hom g, etc. (Specify)	ne, farm, stri	eet, factory, office	9		Location (Stree City or Town, S		er or Rural F	Poute Number,	
Hospi 24 hours 11 cal	Certifier 1 Certifying Pt (Check only one)	nysician: To the baseliner: On the baseliner	sis of examinatio	edge, death n and/or inv	occurred at the restigetion, in my	time, date and opinion, deet	d place, and o h occurred a	due to the cause t the time, date	e(s) end mar and place, a	nner as stat nd due to th	ed. ne cause(s)	
To the complete complete within 7 of the complete Signature and title of certifier	S.IG Marin	2	_	29c. Lice	nse number	57	29d.	Date signed	(Month) De	iy, Year)		
30. N	Same and address of person who	completed cause	death (Item 2	?3a) (Type:	Print)		J /	10/1	5/2	4	/	

CC - 5 2 4 18

and Mental Hygiene 00 10606

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I LODE	ITEM: #28B PER I	MEO G770 4-12-	99 WR.	Certifica	ate of i	Death		Reg. No.	J	0000	
	1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	V	3. Time of Death	
	Jeremy Kev:	in Bodlev						'		0039 AM	
	-				- 4	b. City, Town, or		10			
. Adminici	PENINSULA REG	IONAL HOSPI	TAL			SALISBU	IRY	WICOM	ICO		
neral ector	230-41-8748	6. Sex 7. Ag		Monti			(Month, De			ace (Stete or Foreign ry) and	
*			10c City Town	n or Location					10	ld. Inside City Limits	
ctor		ck			ville			1 M Yes 2 □			
It be no	10e. Street and Number	. +						ry?			
era lera			Ever in U.S.			ispanic Origin? (S	Specify Yes or No			ın Indian,	
Evantion by Fur		Armed Forces? 1 Yes 2 1 Yes, Give Yeer or Dates:					0				
dical	15. Decedent' (Specify only highest	s Education grede completed)	16a.	Decedent's U (Give kind of	sual Occup work done	ation during most of wo	rking	16b. Kind of Bu	isiness/Inde	ustry	
	Elementery/Secondary (0-12)	College (1-4or			Tuse retired)					
C F	12		Me	chanic		42.14.4.1.11	4F1				
Be va	17. Father's Name (First, Middle, L	.ast)				18. Mother's Na	me (<i>First, Middl</i> e,	Maiden Sumem	e)		
	Kevin B. Bodley					Debra L	ynch				
E E	19a. Informent's Name/Relationsh	ip (Type, Print)									
or tr	Kevin B. Bodley	(father)					x 86, Gr	eenback	ville	, VA 2335	
5 to	20a. Method of Disposition	2 Dameuri from State	20b. Place of cemeter	Disposition (/ y, cremetory of	Veme of or other plea	e)	Date	20c. Location -	City or Tov	vn, State	
- A							3/16/99	Stocktor	n Mai	ryland	
and a	21. Signature of Furneral Service L	icensee	LLCIDEL				5/ 10/ 55	Decemen	I P. CHA.	Lylana	
E & G	Mill D	Dern mo	1129	Holl	oway-l	Melson F	uneral H	lome, P.	Α.		
	23a Part 1 Enter the disease or	complications that caused	the death Do	103	Linder	Ave.,	Pocomoke	city,		851 Approximate Interval Between	
ician dical niner	Immediate Cause (Final disease or condition resulting in death)	a. HOA	DDN	Jury	/					Onset end Deeth	
in end ial-transit Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
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for use		d									
yst ys	Part II. Other eignificant condition	s contributing to death b	ut not resulting Ir	the underlyin	g cause giv	en in Part I.		8 /			
y Ph							10	Yes 2□No	3 ☐ Prob	ably 4□ Unknow	
es the igner igner be d									24b. We	re autopsy findings ilable prior to	
s been sign 2 should be pleted b								en autopsy rmed?	ava	npletion of cause leeth?	
ge 2 should							perfo	ormed?	ava con of d	npletion of cause leeth?	
ge 2 should	25 Was case referred to medical					26 Place of De	perfo	Yes 2 No	ava con of d	npletion of cause	
rector, page 2 should	25. Was case referred to medical examiner?	Hospital:	o M¥n/o	Acceptant 200	DOA Oth	er.	perfo	Yes 2 No	ava con of d	npletion of cause eeth?	
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In director, page 2 should To Be Completed	examiner? XXYes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	y Year) 28b. T	Time of A	28c. Injur	er: 4 Nursing I	ath (Check only of Home 5 Aesi	Yes 2 No	ava com of d	npletion of cause eeth?	
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na fundral bractor: Arier rils certificate has been significated in by the funeral director, page 2 should edical Certification: To Be Completed	examiner? XXYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could netermine 29a. Certifier (Check only one) 1 Certifying Medical E	ation of be best properties of the best properties a sample of the best properties of the b	y Year) 28b. 7 y Year) UNK! Qury - At home, fa c. (Specify) of my knowledge f examination an	rm, street, fac	28c. Injur Wor 1 D tory, offica	er: 4 Nursing I	ath (Check only of the control of th	Yes 2 No one) denca 6 Oth how injury occur LO CON Street end Numb wm, Stete) Couse(s) end ma date end place,	er (Specify red TT 7 St Inner es steend due to	Appletion of cause eeth? Ass 2 No Route Number, Stead. the ceuse(s) Dey, Year)	
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Syling arignoing physician and a strain and	ached for use as the burial-transit and properties are the burial-transit and properties as the burial-transit and properties are the burial-trans	1. Decedent's Name (First, Middle Jeremy Kev: 4a Facility Name (If not institution, PENINSULA REG 5. Social Security Number 230-41-8748 Usual Residence of Decedent 10a. State 10b. County Virginia Accomacy 10e. Street and Number 1425 Ellis Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Bodley 19a. Informent's Name/Relationsh Kevin B. Bodley 20a. Method of Disposition 1 Revin B. Bodley 20a. Method of Disposition 20a. Part I. Enter the disease, or or shock, or heart failure. List of the disease or condition resulting in death) 20a. Part II. Other elgnifleant conditions 20a. Part III. Other elgnifleant conditions	1. Decedent's Name (First, Middle, Last) Jeremy Kevin Bodley	Titem: #288 PER MEU G/7/0 4-12-99 WR.	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Education (Specify only highest grade completed) 1. Decedent's Name (First, Middle, Last) 1. Deced	1. Decedent's Name (First, Middle, Last) Jeremy Kevin Bodley 4a Facility Name (First Middle, Last) Jeremy Kevin Bodley 4a Facility Name (First Middle, Last) PENINSULA REGIONAL HOSPITAL 5. Social Security Number 230–41–8748 3 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Greenbackville 10c. Street and Number 10d. Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed cores? 13. Was Decedent of History or State of Mechanic 15. Decedent's Education (Specify only impliest prode completed) 15. Decedent's Education (Specify only impliest prode completed) 17. Father's Name (First, Middle, Last) Kevin B. Bodley (father) 20a. Method of Disposition 12 Signature of Fuperal Service Leansee 103 Details 2 Cremation 3 Removel from State 1 Decedent's Usual Occup 1 Specify only impliest prode completed) 21. Signature of Fuperal Service Leansee 1 Decedent's Decedent of Hisposition (Meme of Commence), cremency or other prode of the Commence	1. Decedent's Name (First, Middle, Last) Jeremy Kevin Bodley 4a Facility Name (If not institution, give street end number) PENINSULA REGIONAL HOSPITAL 5. Sociel Security Number Losual Residence of Decedent 10a. State 10b. County Virginia Accomack 10e. Street and Number 10c. City, Town or Location Greenbackville 10e. Street and Number 10e. Street and Number 10f. Keyer Married 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Wes Decedent's Ever in U.S. Armed Forces? 11. Wes Decedent's Usual Occupation (Give kind of work done during most of work fire. Do Not use reliev) 11. Wes Specify Cuban, Mexicen, Puer of Dates: 12. Mechanic 13. Mechanic 14. Decedent's Usual Occupation (Give kind of work done during most of work force or other places) 12. Status 12. Status 13. Wes Decedent's Usual Occupation (Give kind of work done during most of work force or occupation. 12. Decedent's Usual Occupation 13. We	Decedert's Name (First, Michide, Last) The Part II. Other eignificant conditions of Deservation of Decedert's Marie (Decedert's Marie	1. Decedent's Name (First, Middle, Last) Jeremy Kevin Bodley 4a Facility Name (Ind. Ind.) Application of Decedent State PENINSULA REGIONAL HOSPITAL Social Security Name by 15. Social Security Name by 15. Social Security Name by 15. Social Security Name by 15. Social Security Name by 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 17/1/1980 18. Was Decedent of Happanic Cripn' (Specify Yes or No-Park of Callant Street) 17. Feather's Name (First, Middle, Last) 18. Was Decedent of Happanic Cripn' (Specify Yes or No-Park of Callant Street) 19. Security Name (First, Middle, Last) 19. Was Decedent of Happanic Cripn' (Specify Yes or No-Park of Callant Street) 10. Street and Number of Real Region of Specify Sp	Decident Name (First, Middle, Last) Very Vear Vear Very Vear	

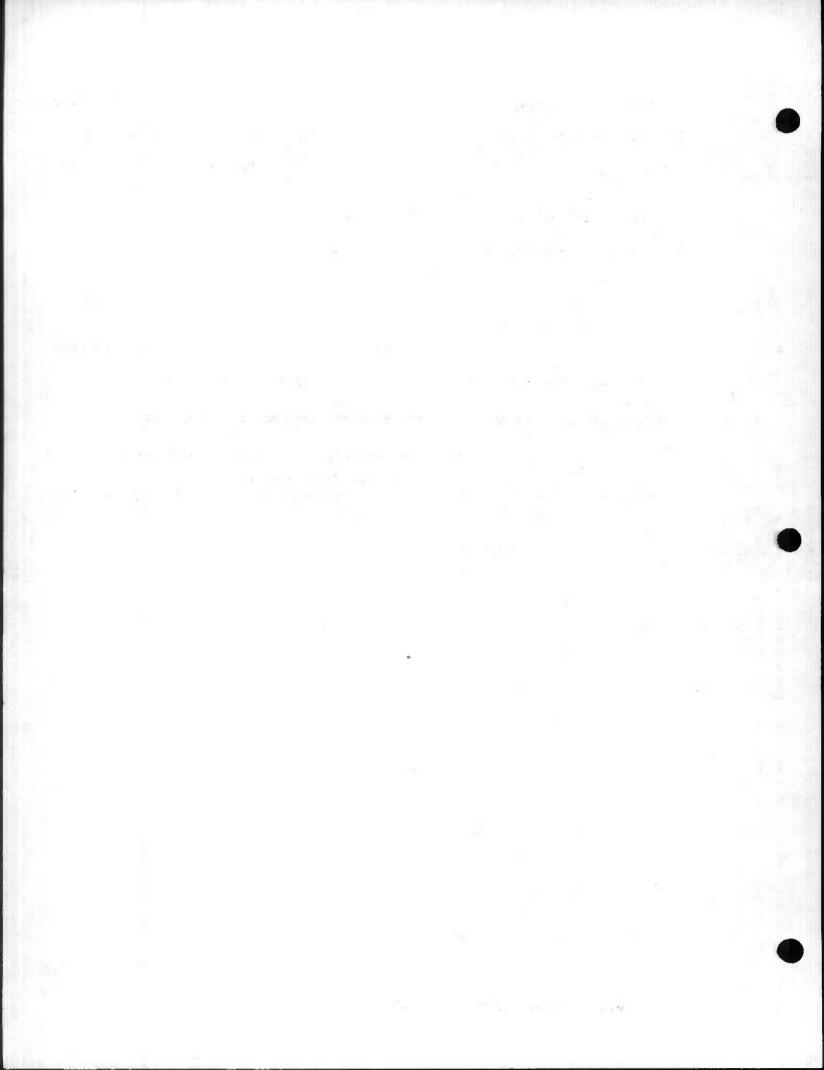
to A. A. Flores

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** Crampton 2:20 am Alice Irene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sharpsburg Washington 3641 Harpers Ferry Rd. If Under 24 Hrs. 8. Date of Birth
Hours Min. Oct. 1929 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1□ M 2⊅F Months Days Yrs. Mary land 220-26-5000 69 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, he Medical Examiner must be notified at 1 Yes X No Funeral Director Sharpsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21782 USA 3641 Harpers Ferry Rd. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Blocker Ribbon Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Martha Irene Hutson 0tho James Kretzer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health er Important: if item 27 is any injury or other trau Melvin C. Crampton/Husband 3641 Harpers Ferry Rd. Sharpsburg, MD 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mt. View Cemetery 3-19-99 Sharpsburg, Mary Land 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Sepheral 022. Name and Address of Facility Home 425 S. Conococheague St.Williamsport,MD Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediete Cause (Final Year disease or condition resulting in death) **Examiner** Physician/Medical Examiner lung The law requires thet the death certificate be executed the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events P.O. Box 68760, the attending physician Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? signed by the 1 Yas 2 No 3 Probably 4 Onknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 212No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours effer death.
To the Funeral Director: After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) by 4 Homicide Ill Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner es steted.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 18 99 shahab Sodiqui, 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 19414-C lei les sour 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State MAR 1 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedani's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 1929 2151 March 22 Catherine Virginia Caudo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Hagerstown Washington County Hospital Washington K Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Hours 1 ☐ M 2 🛱 F Yes 24 9765 Director 83 June 14. Maryland Usual Rasidence of Dacedan the Merylend 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, me Medical Examinar must be notified at 1 Yas 2 □ No Director Washington Maryland Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21740 USA 48 Madison Ave. Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowad 4 ☑ Divorced Yaar or Datas: Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important if item 27 is marked other than any Injury or other traumets. Elamantary/Secondary (0-12) Collega (1-4or 5+) 9 waitress resturant 17. Fathar'a Nama (First, Middla, Last) 18. Molhar's Nama (First, Middle, Maiden Surnama) Be 2 Cora Ethel Selby William H. Roberts 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Anthony J. Caudo, Sr. Son 48 Madison Ave. Hagerstown, Md. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3/25/99Smithsburg, Md. 22. Name end Address of Fecility
Gerald N. Minnich 21-Signature of Funeral Service Licensea 305 N. Potomac St. Funeral Home Hagerstown, Maryland Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Dua to (or as Physician/Medical Examiner hysician and the burial-transit Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in death) Last Due to for as a conse attending physician ea Dua to (or as a consequence of): 88 950 ò P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yee 2 No Division of Vital Records, by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 12801 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminar? 1 Yas 20 No Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Mannar of Deat 28a. Dala of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending P? within 24 hours sited death.
To the Funersi Director: After if completely filled in by the funers edicai Certification: 28b. Time of 28d. Dascribe how injury occurred Natural Accident 5 Panding invastigation Injury 1 Yas 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be detarmined 3 Suiclda Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 | Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29e. Cartifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 1 30. Nama and addrass of puriou who complated causa of death (Item 23a) (Type, Print) PL85 Mil

DHMH 16 Rev 6/95

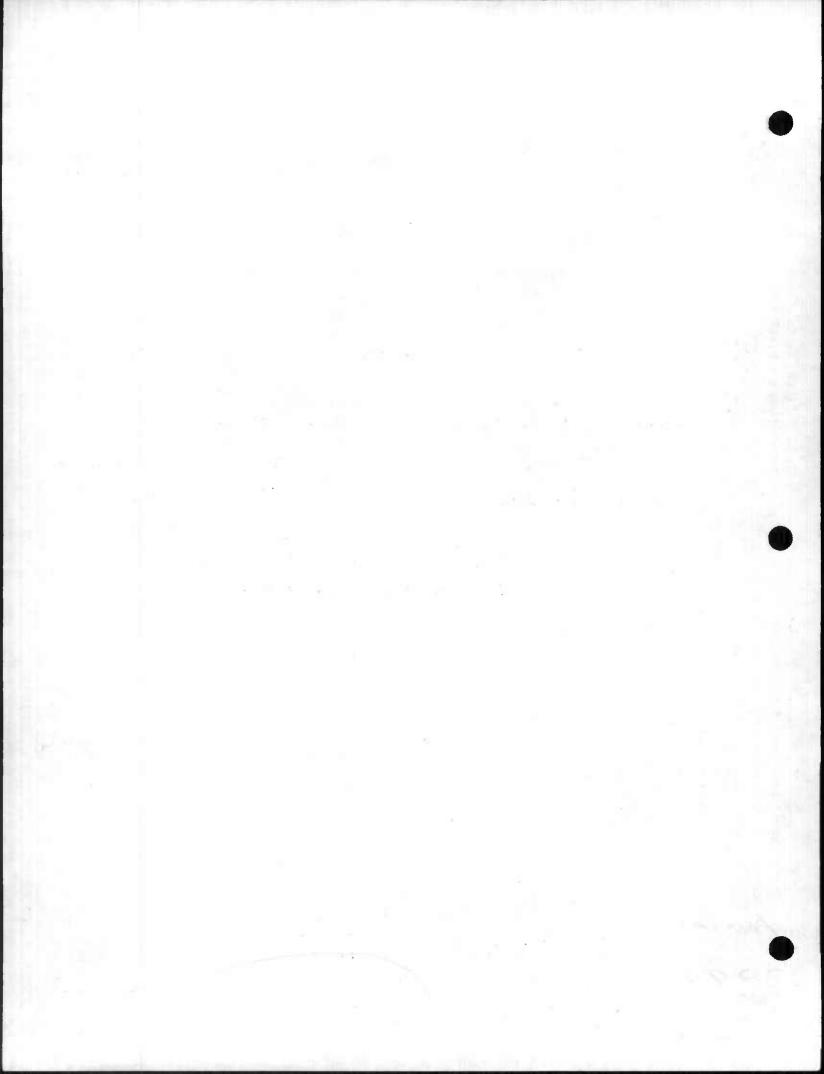
State

Registrar

31. Data filed (Month, Day, Year)

MAR 2 6

2. Registrar's Signatura



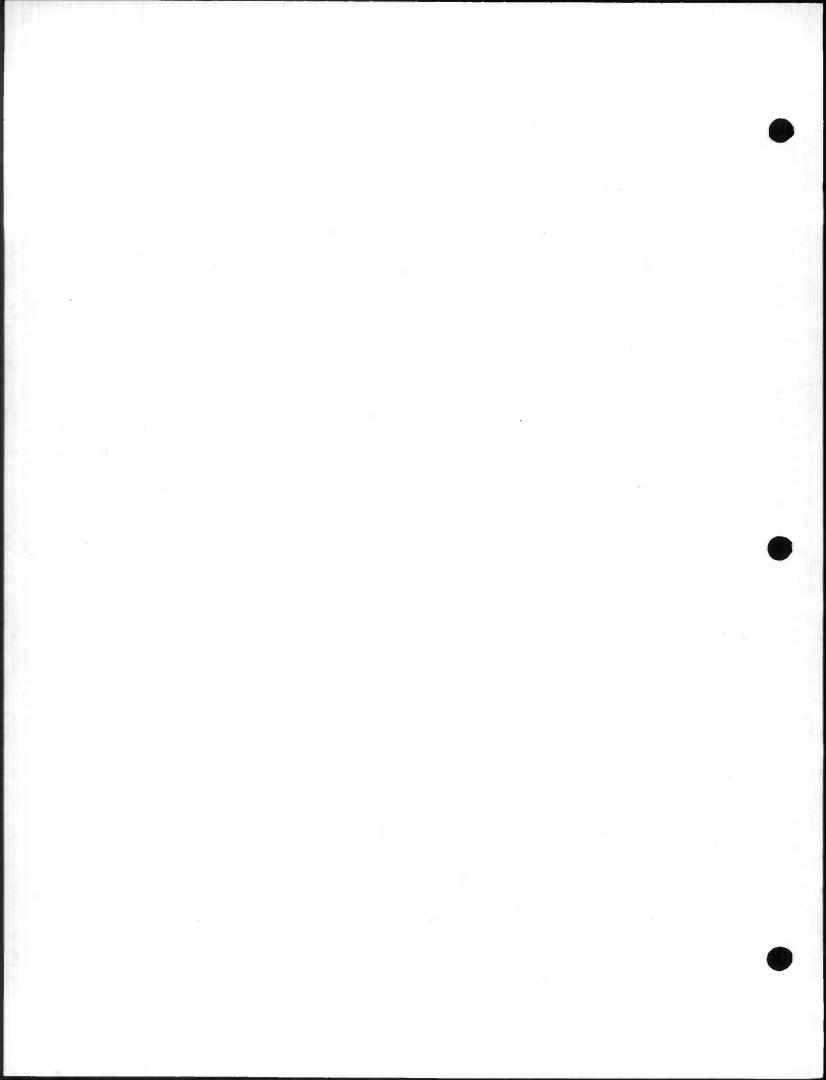
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1, DECEDENT'S NAME (First, Mi		-								*****	OF DEATH	DAY	WEAR.	3. TIME OF DEATH		
	The	lma	Pauline	CAR	PENT	CER					Mar	h 12	, 1999	9 YEAR	8:45 P. M		
	4. SOCIAL SECURITY NUMBER 215-18-2033		5. SEX 1 M 2 X F	6. AGE (H	yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER HOURS	24 HRS. MIN.	7. DATE (Moni Sep	of BIRTH h, Day, Year) t . 5,	1916	6. BIRTNI Country Mary	PLACE (State or Foreign		
OR	9a. FACILITY NAME (If not institute 16704 Black	_							OR LOCATION		EATH			Shing			
<u>ا</u> ي	RESIDENCE OF DECE	DENT 0b. COUNTY				40. 017	Y. TOWN (20100	TION						10d, INSIDE CITY		
DIRECTOR	Maryland		ngton				lager	sto	wn						LIMITS?		
FUNERAL	10e. STREET AND NUMBER	1.	T					1	of. ZIP CODE				10g. CI		HAT COUNTRY?		
崱	16704 Black	berry						\perp	217					U.S.			
В	11. MARITAL STATUS 1 Never Married 2 X Me 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X N	WED O		Il yes, s	CENDENT O pecify Cuba S 2 1 NO		п, Рие⊓о		Yes or No—	Black	4. RACE — American Indian, Black, White, etc. Specify: White		
<u>E</u>	15. DECED (Specify only hi	ENT'S EDUC	CATION Completed			CEDENT'S			TON nost of workin	a	16	. KIND OF I	BUSINESS/IN	OUSTRY			
COMPLETED	Elementary/Secondary (0-12		College (1-4 or 5	+)	life.	Do NOT US	e retired.)		logi or working	9		he	r own				
	17. FATNER'S NAME (First, Middle, Last) Thomas Bernard Spickler 18. MOTNER'S NAME (First, Middle, Melden Surname) Mary Alice Hollinger													iger			
TO BE	19a. INFORMANT'S NAME (Type Mr. Earl Car		r/husbar	nd									own, State, Z		land 21740		
	20a. METHOD OF DISPOSITION 1 2 Burial 2 Cremation	N 3 🗆 Remo		20b.	PLACEA	NODATE	OF DISPOS	SITION (/	Vame of		DAT	E 20c.	LOCATION -	- City or To			
	4 DonsHon 5 Other (Sp 21. SIGNATURE OF FUNERAL S		ENSEE	_ DI	Jau	TOLU	-		AND ADDRES								
	100	21%	MI	in	ul	el	17								1 Home vn, Maryland 21740		
	23. PART i. Enter the dise ahock, or hear IMMEDIATE CAUSE (Final	rt fallure. I	omplications the				not enter	the m	ode of dyl	ng, auc	h aa cer	diac or re	spiratory s	rrest,	Approximate interval Between Onset and Death		
	disease or condition reaulting in death)	, ٠	DE R	OR AS A	CONSEC	DUENCE OF	YUS	IT	Es.						year.		
NO	Sequentially list condition		DUE TO	TPE OR AS A	CONSEC	UENCE O	S S /C	N							1048ar.		
ICAT	If any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury	G	PROI		LE	BI	2 EAS		CA	Re	NOF	7 A			14 ear		
CERTIFICATION	that initisted eventa reaulting in death) LAST		1	(OH AS A	CONSEC	JUENCE OF	r):				-						
	PART ii. Other significant	condition	a contributing to	desth bu	it not r	esulting	in the u	nderlyi	ng cause (given in	Part i.		AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
MEDICAL													2 (NO		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
	DID TOBACCO USE	E CONTR	RIBUTE TO CA	USE O	F DEA	TH YE	s 🗆	NO I	JUNC	ERTAI	NØ				, as t j , iie		
Ž	25. WAS CASE REFERRED TO I	MEDICAL			26. PLAC	E OF DEA			9)								
S	1 YES 2 NO		HOSPITAL:	☐ ER/Outp	atient 3	□ DOA	4 Nu		me 5/ Re	eldence	6 🗆 Oth	er (Specify)					
BY PHYSICIAN:	27. MANNER OF OEATH 1 Natural 5 Pe	ending restigation	26a. OATE OF	Pay, Year)	-	26b. TIM	E OF URY M	V	YURY AT YORK?	NO	26d. OE	SCRIBE NO	W INJURY O	CCUREO			
	3 Suicide 6 Co	ould not be termined	28e. PLACE (building	F INJURY , etc. (Spec	— At ho	me, larm,	etreat, lac	tory, off	lce			CATION (Street or Town, St.		er or Rural F	Route Number,		
COMPLETED	opel		CIAN: To the best of												a) and manner as stated.		
BE CO	29b. SIGNATURE AND TITLE O						,,	ophiaon	29c. LICI	ENSE NU	MBER				(Month, Day, Year)		
10	30. NAME AND ADDRESS OF P	ESON WIN	O COMPLETED CAU	MYY ISE OF DEA	TH (ITE	M 27) (Type	, Print)				836			31/5	179		
	MANZA 11 31. OATE FILEO (Month, Day, Yes		S HA F	AR'S SIGN	368 ATURE	191	LL	3 5	TRE	ET	H	PUE	nstc	own	MD21790		
	MAR 17	1999	pene		P	1	loa	Ks	/								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** 18, 1330 MARCH CROWELL GEORGE B . /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** QUALITY INN Social Security Number #310 OCEAN (CITY 17TH STREET WORCESTER If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sex 1M M 2□ F 7. Age (In yrs. last birthday) **Funeral** Deys Months Yrs. 156-09-005 Usual Residence of Decede **Director** 7-11-20 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinet must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1€ Yes 2 No Director OCEAN MANAHAWKIN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 08050 8 CINDY DRIVE USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1/2 Yes 2 □ No If Yes, Give 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specity: Specify þ 3 Widowed 4 Divorced WWII Yeer or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER CONSTRUCTION 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE E. CROWELL BLANCHE BENSON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HER HOBE SOUND, FLA., 33455 20b. Place of Disposition (Name of cometery, cremetory or other place) Date HERBERT CROWELL BROTHER 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ØCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 22. Name and Address of Facility SALISBURY, MD. 21. Signature of Fuperal Service Licensee ULLRICH FUNERAL HOME BERLIN, Approximete Interval Between Onset and Death 23a. Perty-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final MYO CARDIAL disease or condition resulting in death) FEW MINUTES Examiner Due to (or as a consequence of) Examiner SCVD YEVERAL YRS ettending physician and for use es the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Š been si 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? cete hes t 2 No 1 Tes 1 ☐ Yes 2 ☐ No certificete Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) examiner? Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) HOTEL 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: 1X Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident within 24 hours efter deeth To the Funeral Director: / completely filled in by the f 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Medical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

06241

03-18-99

203 SNOW STI SNOW HILL MD. 2/863

State Registrar

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OROTHY

31. Date filed (Month.

Y onne Coleman SS# 214-345638 Baltimore, Maryland 21215-0020

			State of Ma	ryland / Departme	ent of Health a te of Death		0	9 10	701
		Decedent's Name (First, Middle, Last	st)	2		2. Dete of Dee	eg. No. 🧈		Time of Deeth
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/Medi Examir		4e. Fecility Neme (If not institution, give	e street end number)	COICI		own, or Location of Death	4c. County	*	
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Funeral		5. Sociei Security Number 6. S	Sex 7. Age		der 1 Year if Under			9. Birthplece (Country)	Stete or Forei
Director		214-34-5639 1	□M 2/0 F	62 Yrs. Morning	is Deys Hours	12-14	-36	Country	nD.
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the A	ect	100. Street end Number	JET	Opper F	Zip Code		On Citizen of	Whet Country?	
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feeth me 23	Funeral Director	2 MYO JONES -	12. Was Decedent Ev Armed Forces?	ver in U,S. 13. Was De	cedent of Hispenic Or	igin? (Specify Yes or No-	14. Rac	ce - American Inc	tien,
r Her	Ē	1 ☐ Never Married 2 Married	1 ☐ Yes 2 No	0		igin? (Specify Yes or No- n, Puerto Rican, etc.)	Bla	ck, White, etc.	
72 hours effer deeth with the Maryland natural, or Items 23s or 28s-f show size Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1 00 Yes	s 2 No Specify:		Specif	Black	
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buld be filed within Mental Hygiene. Brked other than atic event, tra Me		12th grade		LINE -	Worke	F	SUPP	riset	10.
be fi	Be	17. Father's Name (First, Middle, Last)	10/		18. Moth	er's Name (First, Middle,	vielden Sumen	ne)	
should nd Men marke umatic	7	100 Informantia Nama (Palatianahia C	IUn Max		700	an J0/	NSON	State Zin Code	
CI 0 10 0		19a. Informent's Name/Relationship	(ypay Frint)	1 2 70 UN	Ta - C-	er or Rural Route Number	City or Town	: / / a - /	2101 -
permit. Pages 1 end 3 Department of Health Important: if item 27 i any injury or other tra pncs.		20e. Method of Disposition	MUNCHUSI	20b. Plece of Disposition (Neme of	Tory Co. V	20c. Location	City or Town, S	C 10 6 /
0		1 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify		cemetery, cremetory of	or other plece)	107 5665	1	1.11 no	1
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g Phy er thi		27. Manner of Deeth	28e. Date of Injury (Month, Dey		28c. Injury et Work?	28d. Describe h			
Attending F r death. ector: After by the funer	atio	1 Neturel 5 ☐ Pending Investigation		Year) Injury M	1 Yes 2	No			
I or Attendi efter death. Director: A d in by the fu	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	e 28e. Plece of Injury building, etc.	ry - At home, farm, street, fac (Specify)	tory, office	28f. Location (S City or Town		ber or Rural Rou	te Number,
ital or is effe al Dir led in									
Hospital 24 hours Funeral stely filled	edicai	(Check only 2 Medical Exam	ysicien: To the best of	my knowledge, death occurrexeminetion end/or investigat	red et the time, date er	nd plece, end due to the c	euse(s) end mate end plece.	enner es steted.	euse(s)
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Med	one)	end menner state	ed.					
or vit		29b. Signeture end title at certifier),		29c. License number		. 1	ed (Month, Dey,	
		4 con	cy, n		1577-6 1	4. Jalis	1 (13)	K	
	l	30. Neme end eddress of person who	completed cause of dee	eth (Item 23a) (Type, Print)	,	, , , , , ,	6		200
Sta	ite	31. Date filed (Month, Dey, Year)	32. Fegistrar	's Signature	owen 1	d, Jakir	DUV	y, M	9 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rsv 6/95

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Phys /Me Exa Fune Direct

1. Decedent's Name (First, Middle, Last)

permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, in Medical Examinations must be notified at

Crouse

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within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use es the bunal-transit

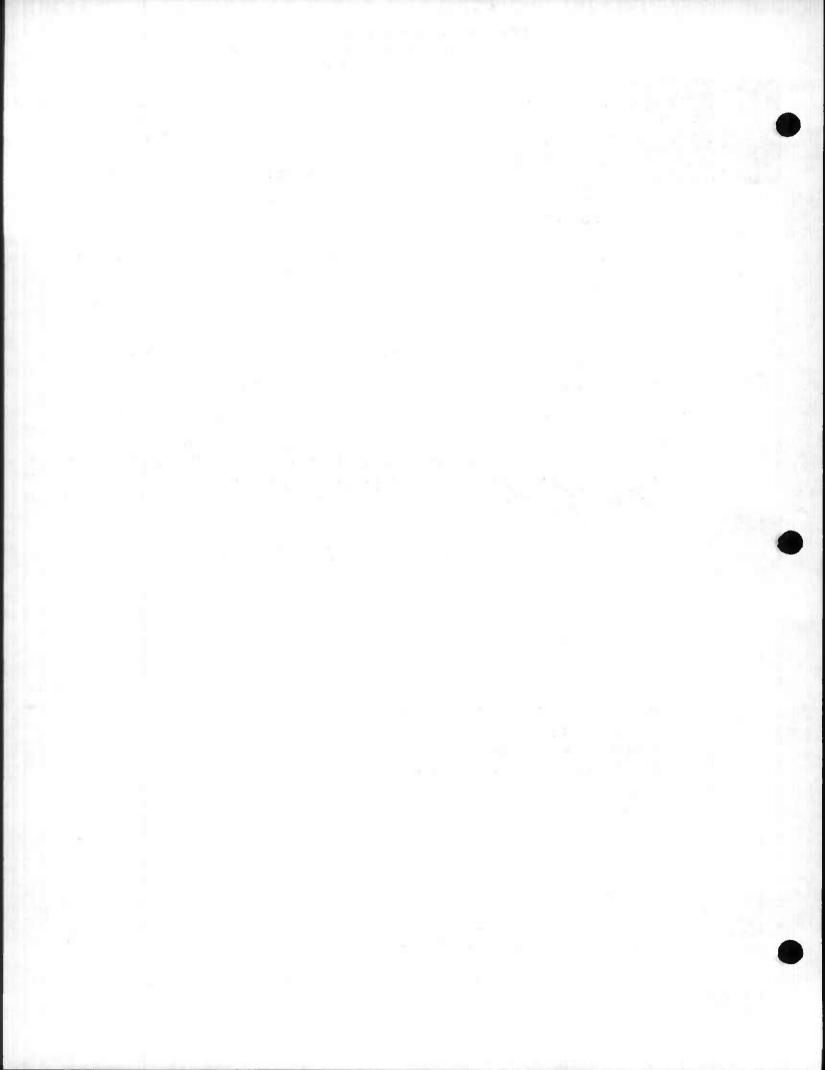
To the Hospital or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760,

ici: dic		Rose Marie Crouse				Month MAR.	21. 199	Yaer 9	9:40 PM
nin		4e. Fecility Neme (If not institution, give street and number)			4b. City, Town, or I	- 21 - 11 - 11 - 1			
		CIVISTA MEDICAL CENTER			LA PLAT		CHAR	LES	
al or		214-32-8735 1□M 2XF	rrs. last birthday) 55 Yrs.	Months Deys	Hours Min.	8. Dete of Birt (Month, De)	y, Year)	9. Birthple Countr Dhio	ece (Stete or Foreign ry)
		Usuel Residence of Decedent 10a. Stete 10b. County 10c.	City, Town or Loc	ation				10	d. fnside City Limits
	Po	Maryland Charles Na	anjemoy						1 ☐ Yes 2 No
	rec	10e. Street end Number	an jemoj	10f. Zip Code			10g. Citizen of V	/het Countr	ry?
	ai D	Bowie Road		20662)		United	Stat	- 69
	ner	11. Maritel Status 12. Was Decedent Ever in Armed Forces?	13. V		Hispenic Orlgin? (Spen, Mexican, Puert			- America	n Indien,
	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes:		☐ Yes 2 No		rican, etc.,	Specify	k, White, et	nite
	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ant's Usual Occu	pation during most of wor	kina	16b. Kind of Bu	siness/Indu	ustry
	mple	Elementery/Secondary (0-12) College (1-4or 5+)	lifa. D	O NOT use retire	nd)	,g	***		
	S	17. Fether's Neme (First, Middle, Last)	Homem	aker	18. Mothar's Nan	no (First Middle	Her Ho		
	Be	Harry Williams				Kendri		,	
	70	19a. Informent's Neme/Relationship (Type, Print)	19b. Meiling	Addrass (Stree	t end Number or Ru				
		Charles Crouse/Husband			Nanjem				
			Piece of Dispos	ition (Name of		Data	20a Location		
		1 ☑Burial 2 ☐ Cremation 3 ☐ Remove if from State 4 ☐ Donetion 5 ☐ Other (Specify) Nam:	emov B	antiet pla antiet	Church			777 N	faryland
#		21. Signeture of Funerel Service Licensee			ess of Fecility Funera		van jeme	у, г.	20640
once.		mello Min	4	1111ams 270 Hav	s funera thorne	I Home Road, I	, P.A. ndian H	lead,	Maryland
		23a. Pert1. Enter the disease, or complications that caused the dishock, or heart feiture. List only one cause on each ina-							Approximete
n		Shock, or realt reliate 21st only one cause on each mad							Interval Between Onsat and Deeth
al er	ē	Immediata Cause (Finel disease or condition resulting in death) a. CONGES	TIVE	HEA F	RT FI	ALLUR	E	F	ew Monthy
	Jer	Due to	o (or es e consequ	ience of):					
	Examiner	Sequentially list conditions b.	o (or es e consequ	ience of):					
ı		if eny, leading to immediate ceuse. Enter Underlying	,	,					
	lica	Causa (Disaase or injury thet initieted evants resulting in deeth) Lest	(or es e consequ	ence of):					
	₩ W	d							
	slcian/Medical								
		Pert II. Other significant conditions contributing to deeth but not							the cause of death?
	y Phy	ATHERO-SCLEROTIC	HEAR	T DI	SEAJE	101	res 2 No	3 Probe	ably 4 Unknown
	Completed by	DIABETES				24e. Wes	en eutopsy med?	24b. Wer	e eutopsy findings
	Sete	HYPERTENSION				perfo	rmed?	com	lable prior to plation of ceuse aeth?
	E	ATREAL FIBRILI	- A TIO A	/-		101	es 2 No		Yas 2□ No
	BeC	25. Was cese referred to medical			26. Pleca of Dee				
	To I	exeminer? 1 Yas 2 No Hospitel: 1 Inpatient 2	ER/Outpatient	3□ DOA Ot	her: 4 Nursing H	ome 5 Resid	lence 6 Othe	ır (Specity)	
		27. Menner of Death 1 Neturel 5 □ Panding 28e. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. Inju Wo		28d. Describe t	now Injury occurr	be	
	cati	2 Accident investigation			Yes 2 No				
	Certifi	4 Homicida detarmined 28e. Plece of injury - A building, etc. (Spe	t home, farm, stre acify)	et, factory, office		281. Location (5 City or Tox	Streat and Number m, Steta)	r or Rurel	Route Number,
	Medical Certification:	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my keep one with the basis of exemple one meaning the control of the basis of exemple one meaning the control of the basis of exemple one meaning the control of the basis of exemple one one of the basis of exemple one of the basis of the basis of the basis of the basis of the basis of the basis of the basis of exemple one of the basis of the	nowladga, daath inetion end/or Inv	occurred et the ti astigation, in my	me, dete end plece opinion, deeth occur	, end due to the orred et the time, o	causa(s) and ma date end plece, s	nnar as sta and due to t	ited. the ceuse(s)
Ì	Σ	29b. Signature end title of certifier		29c. Licen	se number		29d. Date signed	(Month, D	ay, Year)
		V. Mangand	we	D-26	064		3-2	2-	99
	Ì	30. Name end eddrass of person who completed ceusa of daeth (I							
		VIDYASAGAR ANMANGANDLA, MD.	РО ВОУ	282 C	HARLOTTE	HALL, MI	2062	2	
Stat stra		31. Data filad (Month, Day, Year) MAR 2 4 1999 32. Registrar's Signature of the Signature		1	1				
6/95		IIII/II N I IJJJ	ρυ.	por	4/				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Deeth

3. Time of Death



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 15, CATHERINE C DREXEL MARCH 1999 2315 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner COLLEGE VIEW CENTER FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 10 F Days Hours Yrs. 216-12-2798 93 11,1905 Baltimore, MD Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits them 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at MD FREDERICK 1 ☐ Yes 2 No SABILLASVILLE Directo 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number 17414 NAYLOR RD 21780 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mantel Hygient Important: If item 27 is marked other that any Injury or other traumatic event, Italian pages. 4 NURSE STATE HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) CHARLES E. **FALTER** MARGARET SCHWAB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VICTORIA SIPES/NIECE 8669 RIDGE RD ELLICOTT CITY MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State BETHEL CHURCH CEMET. 3/22 4 ☐ Donetion 5 ☐ Other (Specify) CASCADE MD 21719 22. Name and Address of Fecility GROVE FUNERAL HOME, 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. 50 S Broad ST Waynesboro PA Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LWK neumonia **Examiner** Due to (or as a consequence of): Examiner 01157-ron physician end the buriel-trensit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Sondala Due to (or es e consequence of): Physician/Medical that initiated events resulting in death) Lest 98 esn signed by the e 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 s Seu 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours e Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D 0050767 3/18/99 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Yong S. Lee, MD 174 Thomas Johnson DR Ste 204 Frederick MD 21702

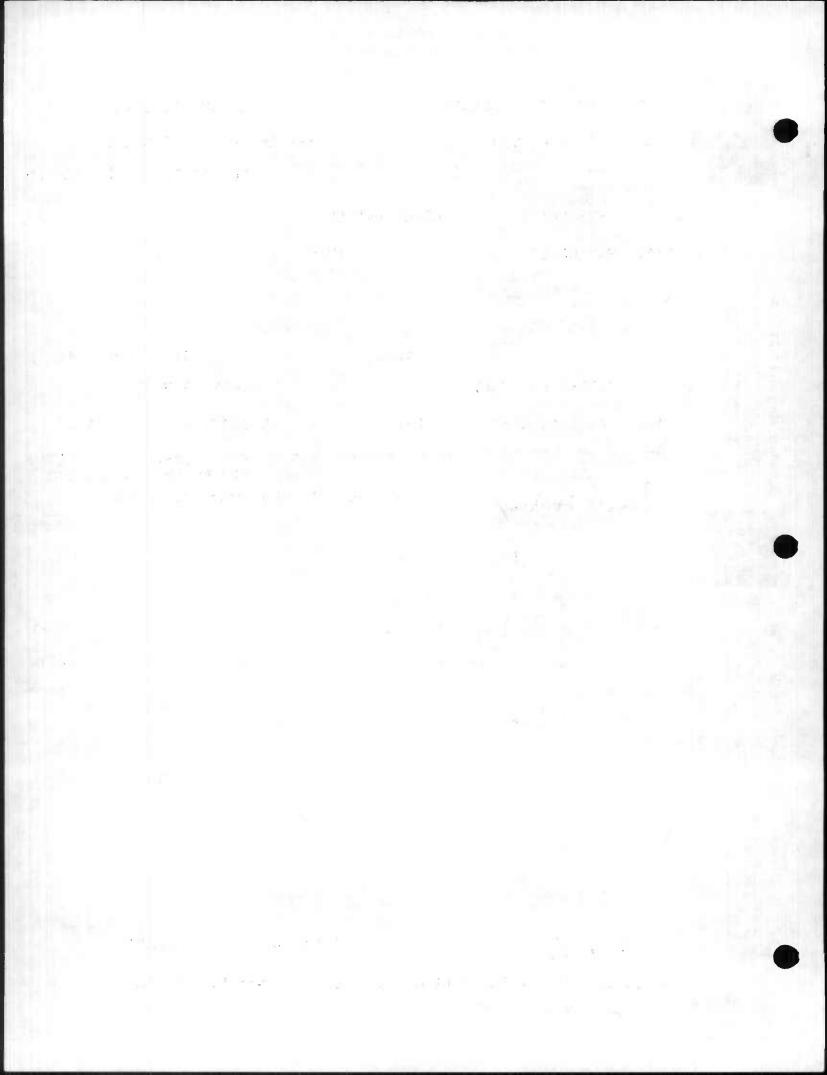
DHMH 16 Rav 6/95

Registrar

31. Date filed (Month, Day, Year) MAR 2 3 1999

32. Registrar's Signature

Darks



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year JAMES RUSSELL DONOWAY 03 23 99 2351 JR /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year if Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 X M 2□ F 216-44-7915 Yrs **Director** 11-04-43 Maryland Usual Residence of Decedent the Meryland Show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Pocomoke 288-1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with ò 2514 Worcester Highway 21851 USA Items 23s deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiena.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried > Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: ð Specify: White 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Construction Carpenter 10 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) James Russell Donaway Sr. Ruth Mary Aydelotte 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health er important: If item 27 is any injury or other trau once. 714 Cedar St., Pocomoke, MD 21851 Ruth Donaway/Mother 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 3/25/99 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 21. Signeture of Fugerei Servica Licansee 22. Neme end Address of Fecility Holloway Melson Funeral Home P.A. 103 Linden Ave., Pocomoke, MD 21851 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete ervel Between Onset end Death Physician /Medical Immediate Cause (Final a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner physician end the burial-transit thet tha daath certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of): Box 68760. thet initieted events resulting in death) Last Due to (or es e consequence of): attanding p as signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 | Yes 2 | No 3 | Probably 4 N Unknown Records, by The law requires 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been si 24a. Wes an eutopsy performed? Completed page 2 s certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💆 DOA this 28a. Date of injury (Month, Dey Yeer) funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Certification: or Attanding 1 XNaturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No hours eftar death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) To the Hospital or A within 24 hours effar To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pieca, end due to the cause(s) and manner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner steted. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) D.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0003599 03-24-99 9 T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 25 Registrar

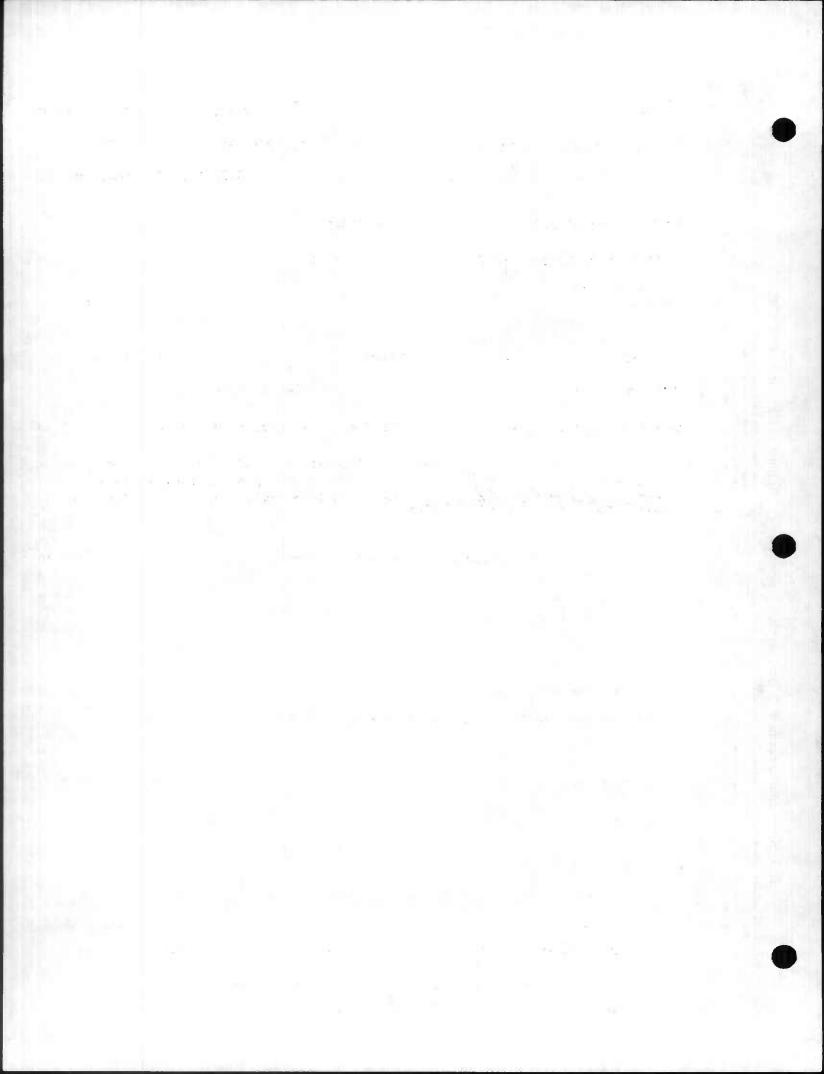
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Venr Month **Physician** Ditto Glenice 1999 11:20AM MARCH /Medical 4b. City, Town, or Location of De 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Baltimore If Linder 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 20 F Vrs **Director** 027-20-0388 July 5 1925 Massachusetts Usual Residence of Decedent the Marylend 10d. Inside City Limits 10e. Stata 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen nant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, tra Marical Examener must be norified at 1 ☐ Yes 🏖 ☐ No Directo Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 19011 Orchard Terrace Road S.A. 14. Race · American Indien, 21742 12. Wes Decedant Ever in U,S. Armed Forces?
1 ☐ Yes ZX No If Yes, Giva Yeer or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 ☐ Nevar Married 2 ☑ Married 1 Yes 2√ No Specify: Specify. by 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Her own home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Carleton May Allen Glennie Ardell Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Hagerstown, Md. 21742 20c. Location - City or Town, Stete 19011 Orchard Terrace Road Edward W. Ditto, III - Husband altimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Data 1 M Burial 2 ☐ Cramation 3 ☐ Ramoval from Stete permit. Page Depertment of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 3/15/99 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 23a. Part1. Enter tha diseesa, or complications that caused the deeth shock, or heart feilure. List only one cause on each line. not enter the mode of dying, such es cardiac or respiretory arrast, Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 20 minutes pulmonary embolism massive Examiner Due to (or as e consequence of): Examine physicien end the buriel-transit death certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Dua to (or es a consequance of): 98 9SP Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown signed t intraparenchymal corobial Division of Vital Records, by 24b. Were eutopsy findings availeble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? paga 2 s certificate has 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1- Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: After 5 Pending Investigation or Attending 1 Naturei 1 Yes 2 No death. 2 Accident after deat 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide Hospital 24 hours Certifying Phyalclan: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

Madical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29e. Certifier edical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signeture and title of certifier 29c. Licansa number 29d. Deta signed (Month, Day, Year) RES-000 March 11, 1999 MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9au | Wang 60.

31. Dete filed (Month, Dey, Year)

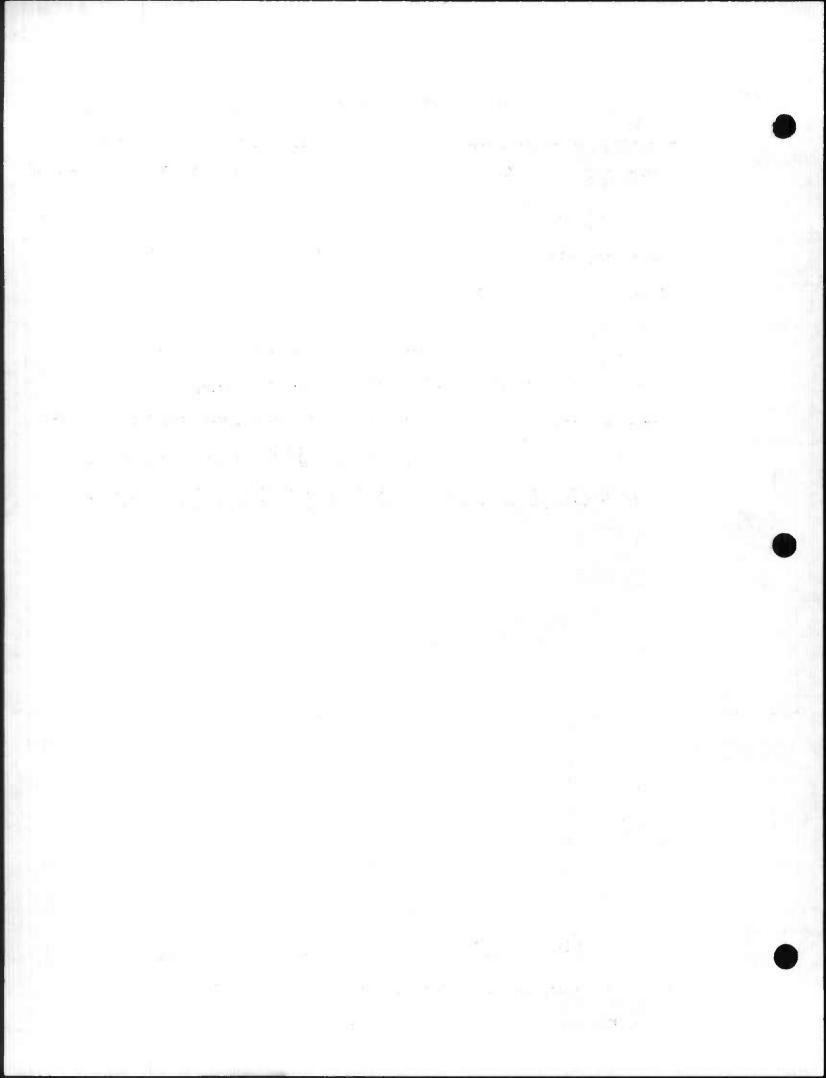
MAR 1 6 1999 Baltimore, North Wolte 21287 600 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

		1. Decedant's Nama (First, Middla, L	ast)					Death	2. Data of Dat		3.	Time of Use th		
Physici /Media	-		Irene	Eliza	beth	Eber	sole	9	March	22 19	999 6	:06		
Examir		4a. Facility Name (If not institution, g	ive street and number)			1	4b. City, Town, or		4c. County	of Death			
		Mennonite Old Pe	ople's Hor	ne				Hagersto			nington			
Funeral Director		5. Social Sacurity Number 6. 217-30-5457 Usual Rasidence of Dacadent	Sax 7. A 1□ M 204 F	ge (In yrs. le C	ast birthday) 4 Yrs.	If Undar Months	1 Yeer Deys	If Under 24 Hrs Hours Min.		, Year 904	9. Birthplaca Country)	(Stata or Fore Mary land		
/and		10e. Stete 10b. County			, Town or Lo					_	10d. tr	nside City Lin		
Tilled a	tor	Md. Washir	igton	F	lagers	town					1	□Yas 2Å		
23a or 28	Funeral Director	10e. Street and Number 13436 Maugansvi	lle Rd.			10f. Zip	Coda 217	40		10g. Citizan of V				
permit. Pages I and 2 should be lifed within 72 hours after death with the Marylar Indepartment of Health and Mental Hygiens. Indepartment of Health and Mental Hygiens. Indepartment if term 27 is merked other than "natural", or from 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 SNevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forces 1 Yas 2 If If Yes, Give Yaar or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes		lispanic Origin? (S en, Mexican, Puerl Specify:	pecify Yes or No- o Rican, atc.)	or No- 14. Race - Ama Bleck, Whit Specify: Wh		dlen,		
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nd z snound kith and Martin 27 ie mart	To	19a. Informent's Name/Ralationship (Type, Print) Harold Williams 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, 14436 Clear Spring Rd. Williamspor												
permit. Pages 1 and 1 Department of Health Important: if I tam 27 i any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) 20b. Place of Disposition (Nama of camatory or othar place) Miller'S Mennonite Church Cemetery 3/25/99 Leitersb												
Departri Importa any inju		21. Signature of Funarai Service Lica	Insea Timbin		²² Z	. Name an	nd Addre	And Son	Funeral	Home I	nc. Pa. 172	a. 17225		
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After	Certification:	1 Natural 5 Panding 2 Accidant invastigate 3 Suicide 6 Could not	00 000 01000 0110		28b. Tima of tnjury	М		yat k? Yas 2□No	28d. Dascribe h			ite Number		
within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide datarmined	building, a	tc. (Specify)				ne dete end als	City or Tow	m, Stata)				
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ithin de	29b. Signature end titla of cartifor 29d. D									29d. Data signe	d (Month, Day,	Year)		
3 1 8 1		$=$ \mathcal{M}_{ℓ}	200 116	1										
- ≱ ⊨ 8		30. Nama and addrass of person who	Madelle				D11	1266	1	March 2	3, 1999			

DHMH 16 Rav 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 5:16 pu March Wheeler Carroll FORD 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, giva street and number) 4c. County of Deeth Washington County Hospital Hagerstown Washington If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) Hours Months 82 217-10-2822 Nov. 27 1916 Maryland Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 15736 Shinham Road 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, atc. 1 Nevar Married 2 Merried 1 ☐ Yes 2 🛣 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year of Pates / Korean 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Farmer His own farm 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Benjamin Franklin Ford Bezzie Mae Cline 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Robin Creek - Daughter 15814 Shinham Road Hagerstown, Maryland 21740 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 remetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 3/16/99 Hagerstown, Maryland 22 Name and Address of Fecility 21. Signeture of Fygeral Service Licansee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final gastroantestinal 3 day 5 disease or condition resulting in deeth) Thrombocy ppenia tepatic Due to (or as a consequenca of): 23b. Did tobacco was contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. a theros derotici 10 Yes 2000 3 Probably 4 Unknown ardious opatus 24a. Wes an eutopsy performed?

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natuary injury or other traumatic event, the intermediate of the intermediate or other traumatic event, the intermediate or other traumatic event, the intermediate or other traumatic event, the intermediate or other traumatic event, the intermediate or other traumatic event, the intermediate or other traumatic event, the intermediate or other traumatic events.

Directo

à

Completed

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical thet initieted events resulting in death) Lest

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yas 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical axaminar? 1 Yes 2 No 27. Menner of Death 1 Neturel
2 Accident

5 Pending Investigation

28e. Dete of Injury (Month, Dey Year) 6 Could not be 28e. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

Hospitel:

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only

3 ☐ Suicide

4 ☐ Homicide

Be

edical

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

MAR

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and address of person who completed cause of daeth (Item 23a) (Typa, Print) 354 Wil

Mary E. mD, 31. Date filed (Month, Dey, Year)

E Money

32. Magistrer's Signetura

treet Hagerstown, MD 21740

Registrar

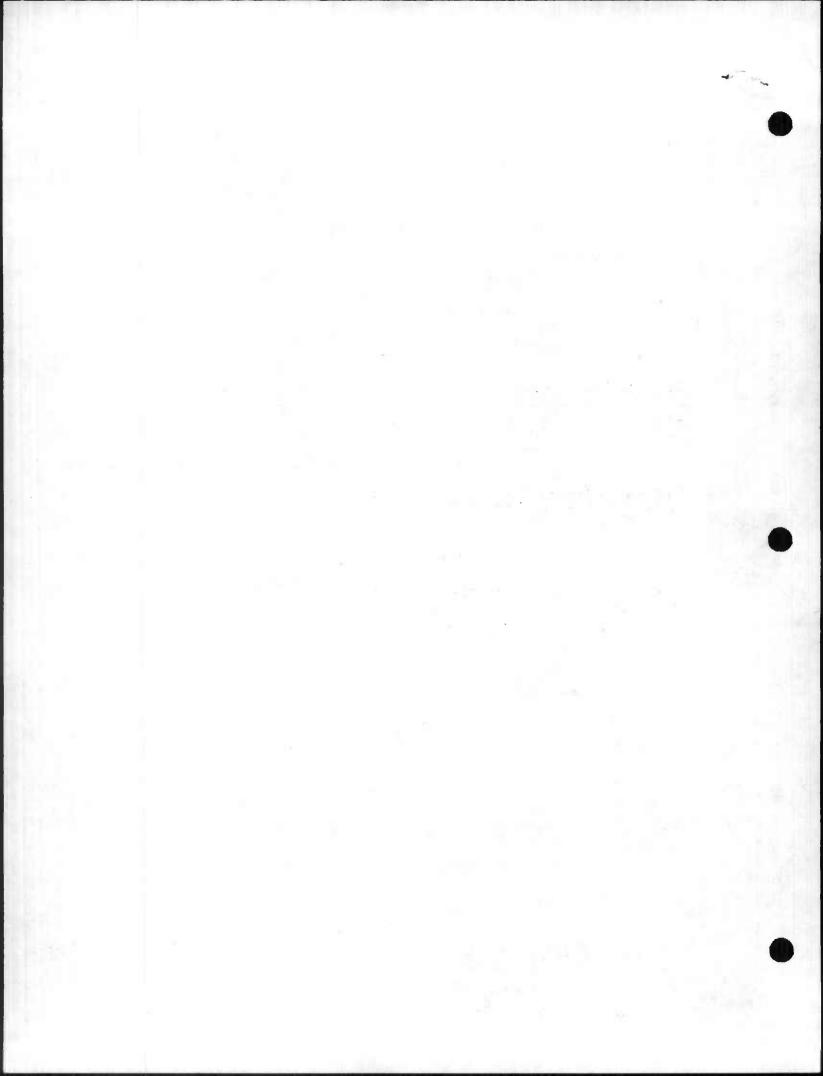
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24 hours after death. Funeral Director: Al

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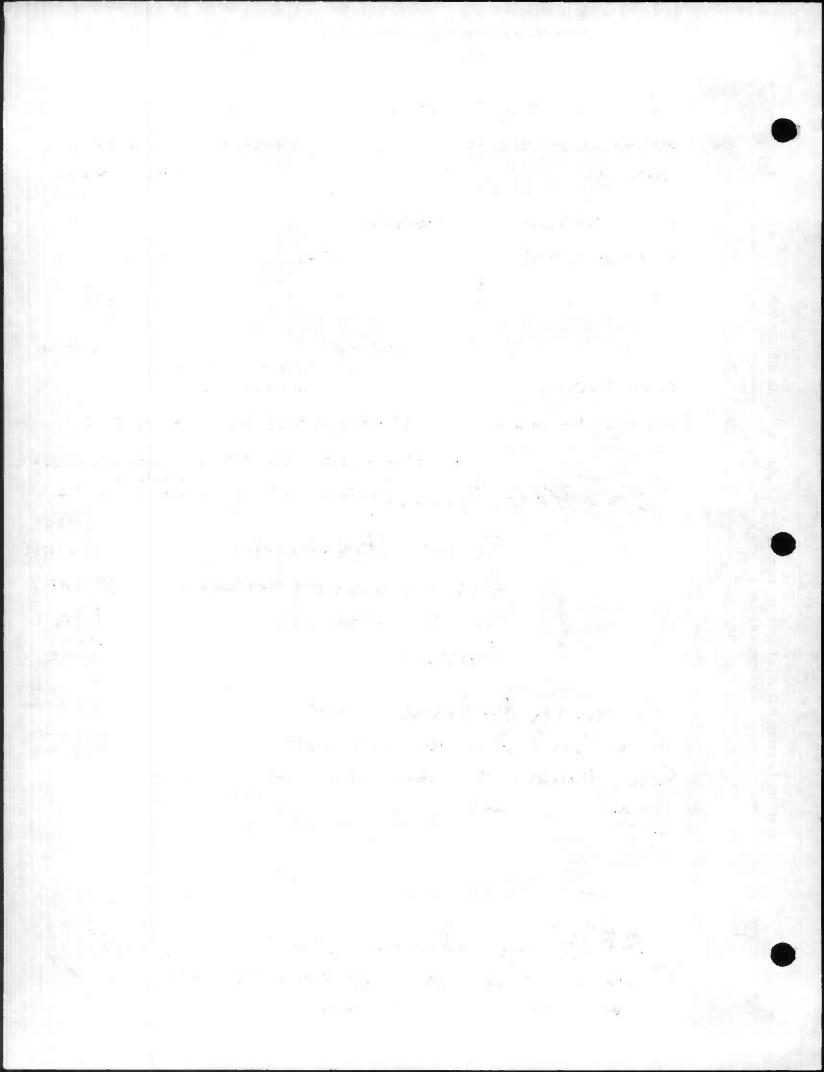
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00

to Be Completed by Funeral Director	Md. Was 10e. Street and Number 11709 Peacoc 11. Marital Status 1 Never Married 2	Maraa itution, give street en County Hos 6. Sex 1 M 2 M	spital 7. Age (in yr.		Months Day		stown	Washir					
Evanine rount be notified at the control of the con	Washington (5. Social Security Number 110-26-2545 Usual Residence of Decede 10a. State 10b. Co. Md. Was 10e. Street and Number 11709 Peacod 11. Marital Status	County Hos 6. Sex 1 M 2 Z	spital 7. Age (in yr.		Months Day	Hager ar If Under 24 Hrs	Location of Death	Washir	of Death				
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Examiner must be by Funeral [11. Marital Status 1 Never Married 2				10f. Zip Code			10g. Citizen of W	/het Country?				
	1 Never Married 2	ck Trail			2	1742		U.S.A	١.				
			Decedent Ever in ed Forces?	U,S. 13	3. Wes Decedent o	f Hispanic Origin? (Suben, Mexican, Puer	Specify Yes or No-		e - American Indian,				
	1 Never Married 2 Merried 1 Yes 2 1 If Yes, Give 3 Widowed 4 Divorced Yeer or Dates:												
	3 ☐Widowed 4 ☐ Div	orced Yee	s, Give or Dates:		1□ Yes 2X N	o Specify:		Specify:	White				
mplet	15. Dec	eadent's Education		16e. De	cedent's Usual Occ	upetion		16b. Kind of Bu	siness/Industry				
E E		highest grade comple		- (Gi	ive kind of work dor a. DO NOT use reti	ne during most of wo red)	rking						
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F 0	17. Father's Neme (First, Mi					18. Mother's Na	me (First, Middle,	Maiden Sumem	е)				
even Be	Ellsworth Hi	i 1 lea met				F131	- t-la						
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raumatic event, I	19a. Informent's Neme/Rela	ationship (1ype, Prini	,					Stete, Zip Code)					
r other tra	Judith Acord	i - Daught	er	117	09 Peaco	ck Trail		own, Md.	21742				
	20e. Method of Disposition 1 XBuriel 2 ☐ Creme	ation 3 Demoval		cametery, c	sposition (Name of tremetory or other p	elace)	Date	20c. Location -	City or Town, State				
17.0	4 Donetion 5 Olh			dar La	wn Memor	ial Park	3/20/99	Hagers	stown, Mar				
Important: If	21. Signature of Funeral Se	vice Licensee	0 -		22. Name end Add		Minnich						
1 1 1	1600	911	Vh		4/5 E.				Md. 2174				
	23a. Pert1. Enter the disease	4///	Iles	mul	and the same of th		_						
	shock, or heart feilure.	List only one cause	on each line.	ath. Do not i	and thought of c	lying, such as cardia	C OI respiratory er	1621,	Approxime Intervel Be Onset and				
ician			C		16				11.				
dical niner	Immediate Ceuse (Finel disease or condition		SEVE	15	17410	Xtmin			Min				
	resulting in deeth)	0.	[] Due to	(or es a con	sequence of):	ALMIA			11				
		- h	11/48510	JETI	ucmon.	ANG CI	usorce	2	Muru				
E E	Sequentially list conditions,	D	Due to	(or es e cons	sequence of):				1				
es the bungi-transit fedical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		1)6701	16711	THRUM	130515			1)A4				
edicai Examiner	that initiated events	C	/ Due to	(or es e cons		, ,,,,			O.C.				
2	resulting in death) Lest		1,100	2	1				LIM				
by Physician/M		d	NACT	1011	-1				lut				
Ca	Deat II Other steelings	- dial	As death but sate			shore to Book t	ash Did	lahanan una ann	ntribute to the cause				
, A	Part II. Other significant co	nations contributing	to death but not re	esuiting in the	underlying cause	given in Pert I.		TORKS TO SERVICE	21/4/12/12 14 152 154				
by Physician/M	Leun	ITIC/	us HBS	scer(Klat	7	1 -	Yes 2L No	3 Probably 4				
by	0		1.		*				24h 14/a-a				
To Be Completed	CHEST	DUE 10	METHIC	cu	RESS	mor	24a. Was perfo	en autopsy med?	24b. Were eutopsy eveilable prior completion of				
mpleted	6	(-			, 7				of deeth?				
PO	CTACH A	uneul -	ACZH	Elme	n { Don	16NTIA	101	res 2 No	1 ☐ Yes 2				
0	25. Wes case referred to m	edical	71 .(.		(3 /) 4/	26. Place of De	ath (Check only o	ne)					
B. 0	examiner?	Hospital:	18 Inpatient 2	□ EB/Outpot	tions 3 DOA	Whoe	Home 5 ☐ Resid		er (Specify)				
rel director, page	27. Menner of Deeth	28a.					_	now Injury occurr					
completely tilled in by the funeral	1 € Natural 5 □ P	rending nvestigation	Date of Injury (Month, Dey Year)	Injur	y V	vork? □ Yes 2 □ No							
Ca	3 ☐ Suicide 6 ☐ C	could not be	Diago of Injury At	hama farm			20f Location /	Street and Numb	er or Rural Route Nu				
ŧ	4 ☐ Homicide d	etermined 286.	building, etc. (Spe	cify)	street, fectory, office	78	City or Tox	vn, Stete)	er or rigrar riodle rid				
edical Certification:													
a C		fillying Physician: T							anner es steted. and due to the cause				
8	one)	and	manner stated.	netion and/or	arvestigation, arm	y opinion, deeth occ	uned et the time,	oato ono piaca, i	and due to the cause				
Σ	290. Signatury of the of	driyler	1 0	\	29c. Lice	ense number		29d. Date signed	d (Mogith, Day, Year)				
	Mhel	ALV TA	WILL	HUSICA	A D	1706		2/11	199				
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	30. Name and address of pe	STSOFT WEST SOFT STATES	couse of deeth (It	em 23e) (Typ	Print)	Takes !	Au- H	Herit	were like				
	11 /14/1	E . 1115-11	aller W		/ / / / / ////								
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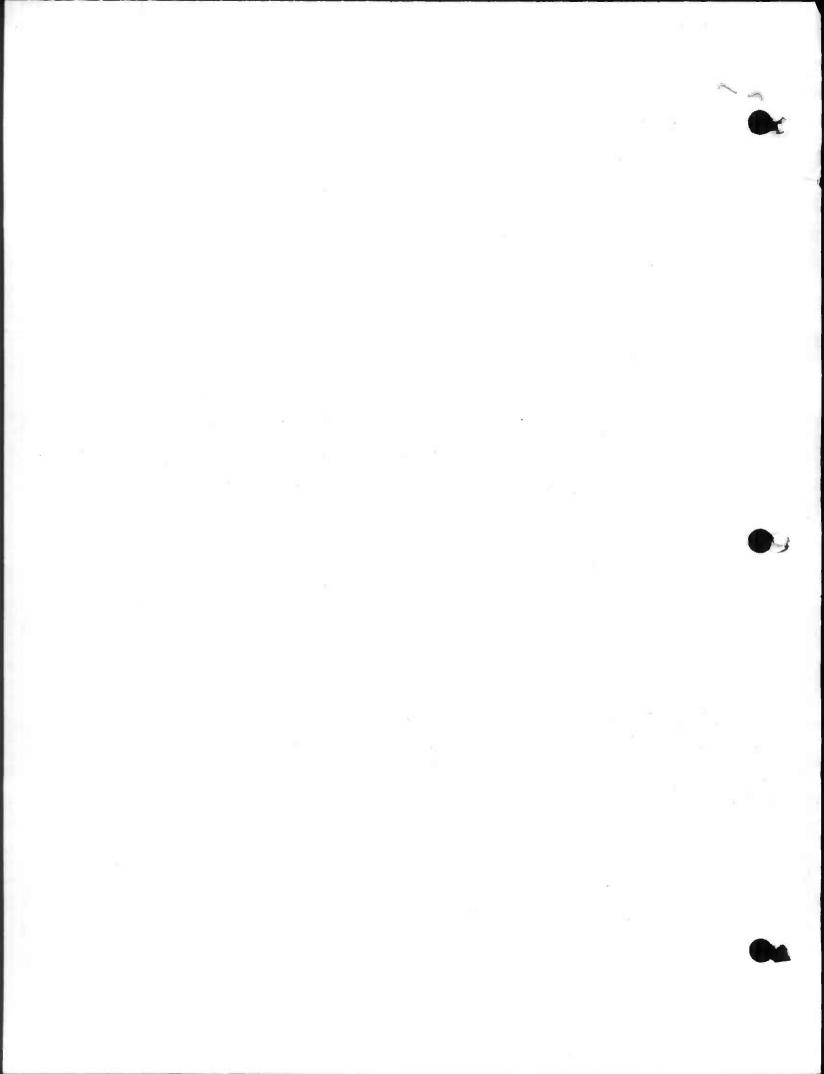
Ruth Margaret Gaffga



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Memail Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1. DECEDENT'S NAME (First, M	fiddle, Last)								2. DATE O		AY	WEAR	3. TIME OF DEAT	N	
	Vickie Kay G	REEN								MONTH 3	2		S S	226	PM	
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE O		-	a. BIRTI	NPLACE (State or Fo	reign	
	213-56-1837		1 🗌 M 2 💢 F	46	YRS.	MONTHS	DAYS	HOURS	MIN.		Dey. Year) 1 19	1952	Count	sh. D.C.		
	9a. FACILITY NAME (If not instit	tution, give str	eet and number)			9b. CITY	Y, TOWN C	R LOCATI	ON OF DE				NTY OF D			
DIRECTOR	1311 Lindsay	Lane					Hag	gerst	town			Wasl	ningt	ton		
EC		IOB. COUNTY			10c. CITY	, TOWN	OR LOCAT	ION						10d. INSIDE CITY		
P	Maryland	Washi	ngton			На	ager	stown	1					LIMITS?	NO	
AL	10e. STREET AND NUMBER							. ZIP CODI				10g. CIT	IZEN OF V	WHAT COUNTRY?		
ER	1311 Lindsay	Lane					1	217	742			Ī	J.S.A	Α.		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT C	F HISPAN	NIC ORIGIN?	(Specify Yes		14. RACI	RACE — American Indian, Black, White, atc.		
ВУ Е	1 Never Married 2 X M 3 Widowed 4 Divorce		IF YES, GIVE V	YES 2 X	10			2 XNO		in, Puarto Ri y:	can, etc.)		Spec	rity:		
														White		
COMPLETED	15. DECED (Specify only h	DENT'S EDUCA highest grade of	ATION completed)	(G	CEDENT'S	rork done	during mo		ng	16b. I	KIND OF BU	SINESS/IN	DUSTRY			
빌	Elementary/Secondary (0-12	2)	College (1-4 or 5	+)	Do NOT us					County Governmen						
M	1.2 17. FATNER'S NAME (First, Midde	dia al anni	1	Ke	cords	Mar	nagei				-		nmer	nt		
								l		ME (First, Mi		,				
BE	Floyd Melvin		on	140		400000	0.40			e11 N						
5			II oh on							Route Numbe			,	1 017/0		
	Michael V. G		- nusban						ne i					nd 21742		
	1 Donation 5 Other (S	3 Ramo	val from Stata	cemetery, cre	metory or of	her niecel				1	20c. LO				1	
	21. SIGNATURE OF EUNERAL	. ,,	INSEE	, nage	ersto	WII (NAME AL	D ADDRE	SS OF FA	CILITY M	/ рэна	gers	COWIL	Maryla L Home	na	
	5	2	MVI		1									nome, Md. 2	17/0	
	200	1 /	11/10	muce										1, Ma. Z	1/40	
	23. PART I. Enter the disc shock, or hea	essen, or co art failure. L	ist only one cau	it caused the de	ath. Do n	ot enter	the mo	de of dy	ing, auc	h an cardle	ac or reap	iratory ar	reat,	Approxim		
	IMMEDIATE CAUSE (Final													Onset and		
- 1	disease or condition a. Me for Mr. RecM (Ancer Tycar) DUE TO (OR AS A CONSEQUENCE OF):															
	DUE TO (OR AS A CONSEQUENCE OF):															
Z	Sequentially list condition	b.														
Ĕ	If any, leading to immedia cause, Enter UNDERLYING	ate	DUE TO	(OR AS A CONSE	DUENCE OF):										
CERTIFICATION	CAUSE (Disease or Injury		DUE TO	(OR AS A CONSE	HENCE OF	٥.										
Ē	that initiated eventa reaulting in death) LAST		502 10	(ON AS A CONSE	JOENCE OF).										
E		d.														
A	PART II. Other significant	conditiona	contributing to	death but not r	esulting i	n the ur	nderlyin	g cauae g	given in	Part i.	24a. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FI		
MEDICAL										1	1 TYES 2	-		COMPLETION OF COMPLETON OF COMP		
Ä														1 YES 2 1	10	
	DID_TOBACCO	USE C	CONTRIBUT	E TO CAU	SE OF	DEA	TH Y	YES [1 NC) Pri						
PHYSICIAN:	25. WAS CASE REFERRED TO I	MEDICAL					26. PL			eck only one)					
Sic	1 YES 2 NO		HOSPITAL:	ER/Outpetlant 3	□ DOA	OTHE		• 5 A	sidenca	6 Other	(Specify)					
£	27. MANNER OF DEATH		25a. DATE OF (Month, D	INJURY	28b. TIME	E OF	28c. INJ	URY AT		26d. OESC	RIBE HOW	NJURY OC	CURED			
	1 Natural 5 Pe	ending restigation	(,			M		ES 2	NO							
S I	a Decided	ould not be	26s. PLACE C	F INJURY — At ho atc. (Specify)	me, farm, s	treet, fac	tory, offic			28f. LOCAT	TION (Street Town, State)	and Numbe	r or Rural I	Route Number,		
D BY	- 0 00	(0)00//						Ony or	iowii, State,							
		termined	1													
	4 Nomicide da		IAN: To the best of	my knowledge, de	ath occurre	d at the t	time, deta	and place	and due	to the caus	e(a) and ma	Door as ata	ted			
	4 Nomicide da 29s. CERTIFIER (Check only	YING PNYSIC	IAN: To the best of											a) and manner as s	afed.	
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State of Maryland / Department of Health and Mental Hygiene Q

		Certificate of Death Reg. No.												4 1 0	
Physic	ian	1. Decedent's Name (First,			CT							2. Deta of D Month	Day	Xear	3. Time of Death
/Medi	cal	LOIS	M.	GOUL					Ab	City To	own or l	ocation of Dea		1999	0903
Examir	ner	4a. Facility Name (If not ins PENINSULA R	EGION	AL MEDI	CAL					S	ALIS	BURY		VICOM	
Funeral Director		5. Social Security Number 019-24-2810		Sex 1 □ M 2 X F	7. Age (f.	in yrs. lest b	Yrs.	if Under 1 'Months E	Year Deys	If Under Hours	Min.		Dey, Year)	9. Birthi Coul Mas	oleca (State or Foreig ntry) Sachusett:
Pu Mary		Usuel Residence of Deced			10	Oc. City, To	vn or Loc	cation							10d, Inside City Limits
the Marylar 28a-f show notified at	ector	OWENTED TO	rceste	er		Berl	in	1.01 71 0					T"		1 ☐ Yes 24② No
23 a or	Funeral Director	10e. Street end Number 249 Windjam	mer F	₹d.				10f. Zip Co					10g. Citizen o	f Whet Coul	ntry?
0020 bours after dea uret', or thems at Examiner ma	by	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Div		12. Was Dec Armed Fo 1 Tyes If Yas, Gi Yeer or D	orces? 2 X ☐ No ive	er in U,S.		Vas Deceden Yes, specify ☐ Yes 2		penic Or , Mexica Specity		ecify Yes or N Rican, etc.)		ece - Americ eck, White, ify: Wh	etc.
15-C	rt, the Medical Completed	(Specify only		ede com <i>pleted)</i>		160	(Give I	ant's Usual C kind of work o	done du	<i>irina</i> m <i>os</i>	ng most of working 16b. Kind of Business/Industry				
7 X D 2		Elemantary/Secondary (0-12)	Collega (1-4or 5+)			stered	,				Hos	pital	
⊆ 23°2 €	8	17. Fether's Name (First, M											la, Meiden Sum	ame)	
arylan should be marked o	To.	James Su				T						rbaug			
Ma und 2 st alth and 27 is r		19a. Informent's Name/Rei Normand R.				19							n, Md.	wn, Steta, Zip Coda)	
OTC THE		20a. Method of Disposition	etion 3	Removel from	State	cemet	of Dispos	sition (Neme natory or other	of ir plece)	1	Date	20c. Location	- City or To	
Baltimo permit. Page Department of Important: If any injury or		4 Donetion /5 Ot		fi.f.	(Cape		open Name end				3-23-99	Frank	ford,	Delaware
Ball permit permit permit permit in		·VA	18	1	Mad	1280	. T1	he Ru	rha	ao E	illoo	ral Ho	me		
	1	108 William Street, Berlin, Md. 21811. 23a Varil. Europhy dispase, or complications that caused the deathy. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or want failure. List only one cause on aech line.											811	Approximete	
Physician /Medicai Examiner	-	Immediate Ceuse (Final diseese or condition resulting in deeth)	List Gily	o. Me	1	1 5		lim	4	Can	M	es			Intervel Between Onset end Deeth
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68760, tificete be exago physicien as the buriel.	edical E	Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of):													
× 99 in 98	3														
	iciar												o the cause of deat		
P. O	y Physician	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.										23b. Did tobacco use contribute to the cause of			
aw requ	Completed by											24e. We	es en eutopsy formed?	ev	are eutopsy findings veileble prior to empletion of cause death?
f Vital Reystolen: The lav	Con											10	Yes 2□No	11	☐ Yas 2☐ No
Vita Iclan: Certific	Be	25. Was casa raferred to m examiner?	edical	Hospital:	•				Other		e of Dee	th (Check only	/ one)		
Phys r this aral dii	To :	1 ☐ Yes 25 No 27. Menner of Deeth		1123	Inpatiant of Injury	2 ☐ ER/C	utpatiant Time of			4 🗆 🕅	ursing Ho		sidence 6 CC e how injury occ		fy)
ion ading Fath.: After e funer	atlor		Pending nvastigation	28e. Dete (Mon	nth, Dey Ye	eer)	Injury	М	Injury Work		No				
Division of the death. Director: A din by the fi	Certification:	Accident invastigation M 1 Yes 2 No 3 Suicide 4 Homicide Homicide Street end Number or Rurei 28e. Pleca of Injury - At home, farm, street, factory, office 28f. Location (Street end Number or Rurei 28f. Location (Stree											el Route Number,		
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Cartifier (Check only one)	rtifying Ph	niner: On the b	asis of axa	amination a	e, deeth	occurred et le estigation, in	he tima my opi	a, data er nion, daa	nd plece, ath occur	end due to th	e ceuse(s) end a, data and place	menner es s e, and dua t	steted. o the ceuse(s)
Vithin 2 To the comple	Mec	29b. Signeture end title of o	certifier	end men	nar stated	J.		29c. L	icense	number			29d. Date sign	ned (Month,	Dey, Yeer)
- s F 5		pepe	mo	M					0	20	507)	1	/	
	5	30. Name and address of p	rson who	Completed caus	se of daeth	h (Itam 23a)	(Type, F	Print)	ULL	St	- 5	ALIS	3/2	N	10

State Registrar

RICHARD

State of Maryland / Department of Health and Mental Hygiene
ITEMS: #23 PART I, 27, 28A-FFPER MEO G770 Certificate of Death

Reg. No. HARBAUGH

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Richard Wayne Harbaugh

MARCH

2. Date of Death

Month

3. Time of Deeth 7:05P.M.

4a Fecility Neme (If not institution, give street end number) 10105 CRYSTAL Fall Drive

4b. City, Town, or Location of Death

13,1999 4c. County of Death

Funeral Director

5. Social Security Number 1 M 2 □ F 220-17-1965 Usual Residence of Decedant

Smithsburg Hours Min. 8. Date of Birth (Month, Day, Aug. 27, If Under 1 Year Days Months Aug.

WASHINGTON

"natural", or items 23s or 28s-f shored call Experience must be notified at

Director

Funeral

þ

Completed

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mantal Hygiena. nt: If item 27 is marked other than "natural", or ite

7 is marked other than "nature traumatic event, the Medical

item 27

= 6 permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

physician and the burial-transit

88 esn Physician/Medical Examiner

by

Completed

Be

To

Certification:

edical

funeral

6

To the Hosp within 24 ho To the Fune completely fi

Baltimore, Maryland 21215-0020

10a State Md. 10b. County 10c. City, Town or Location Washington

17

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

1 Yes 2 No

10e. Street end Number

103 W. Water St.

10f. Zip Code 21783 10g. Citizen of What Country? U.S.A.

11 Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

Was Decadent Ever in U,S. Armed Forces? ☐Yes 2 No Yeer or Dates:

13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 No Specify:

 Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

7. Age (In yrs. lest birthday)

Yrs.

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Deliveruman

Smithsburg

16b. Kind of Business/Industry

Restaurant

Elementary/Secondary (0-12)

17. Fether's Name (First, Middle, Last) Harold Wayne Harbaugh 18. Mother's Neme (First, Middle, Malden Sumame) Teresa Lee Redmiles

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 103 W. Water St. Smithsburg. Md. 21783

Teresa L. Harbaugh (Mother)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, Stete

20a. Method of Disposition 1 Burial 2 Cremation 3 Remove Donation 5 Other (Specify)

Smithsburg Cemetery March 18, 1999 Smithsburg, Md. 22. Name and Address of Facility

Davis Funeral Home

12525 Bradbury Ave. Smithsburg, Md. 21783

(21. Signature of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

BRONCHOPNEUMONIA AND ENVIRONMENTAL HYPOTHERMIA

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Due to (or es a consequence of):

Due to (or es a consequence of)

Due to (or as a consequence of)

				•
	1 🗆	Yee	2	3

23b. Did tobacco use contribute to the cause of death?

26. Piece of Deeth (Check only one)

)	2 -No	3 Probably

24a. Wes an autopsy performed?

24b. Were autopsy findings eveileble prior to completion of ceuse of death?

25. Was cese referred to medical examiner? 1X Yes 2 No

27 Manner of Deeth 1 Natural 2 X Accident

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation Found: 3-13-99 6 Could not be determined

17

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 28c. Injury at Work? 1 Yes 2 No Found: 3:00

28d. Describe how Injury occurred

HAD BEEN EXPOSED TO COLD ENVIRONMENT 281. Location (Street end Number or Rural Route Number, City or Town, State) 10105 CRYSTAL FALL DR.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: DIRT LANE INSIDE AUTO

SMITHSBURG, MARYLAND 1 Csrtifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature end title of cartifier

Alypnop

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29c. License number

MARCH 14, 1999

Q. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

O.C.M.E.

29d. Date signed (Month, Dey, Yeer)

State

31. Date filed/Month, Dey, Yeer) MAR 1 6 1999

32. Registrar's Signature

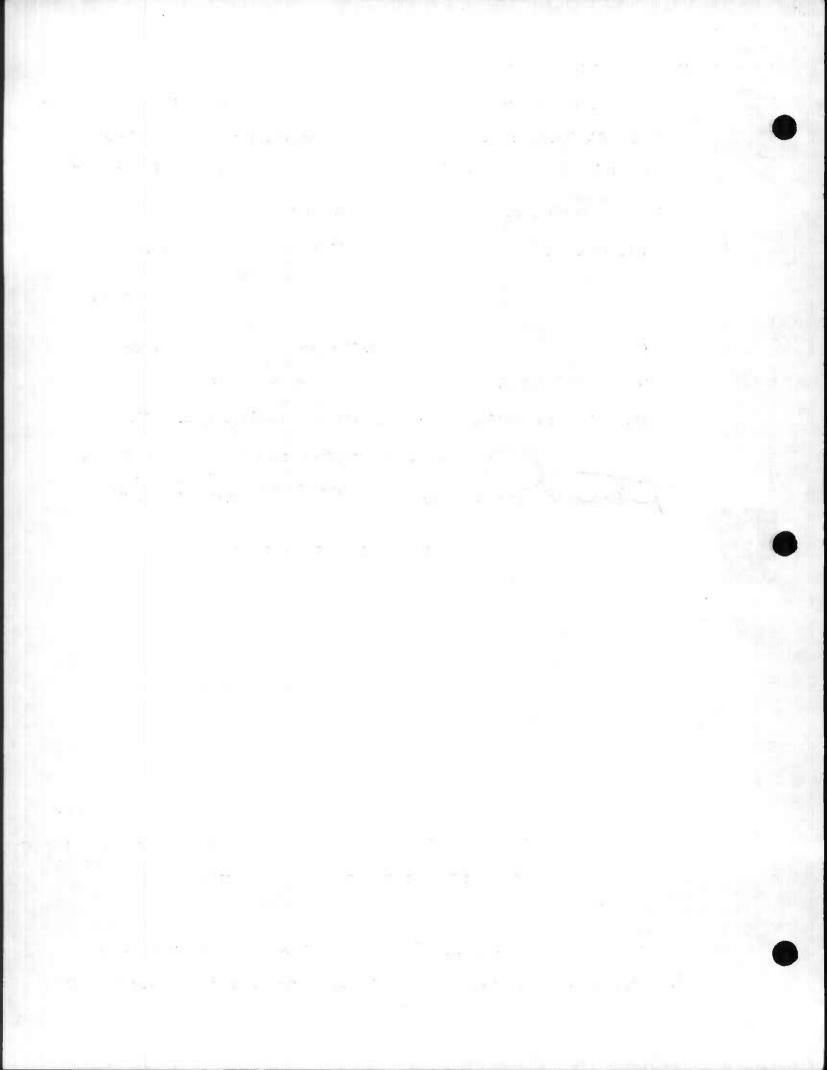
111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

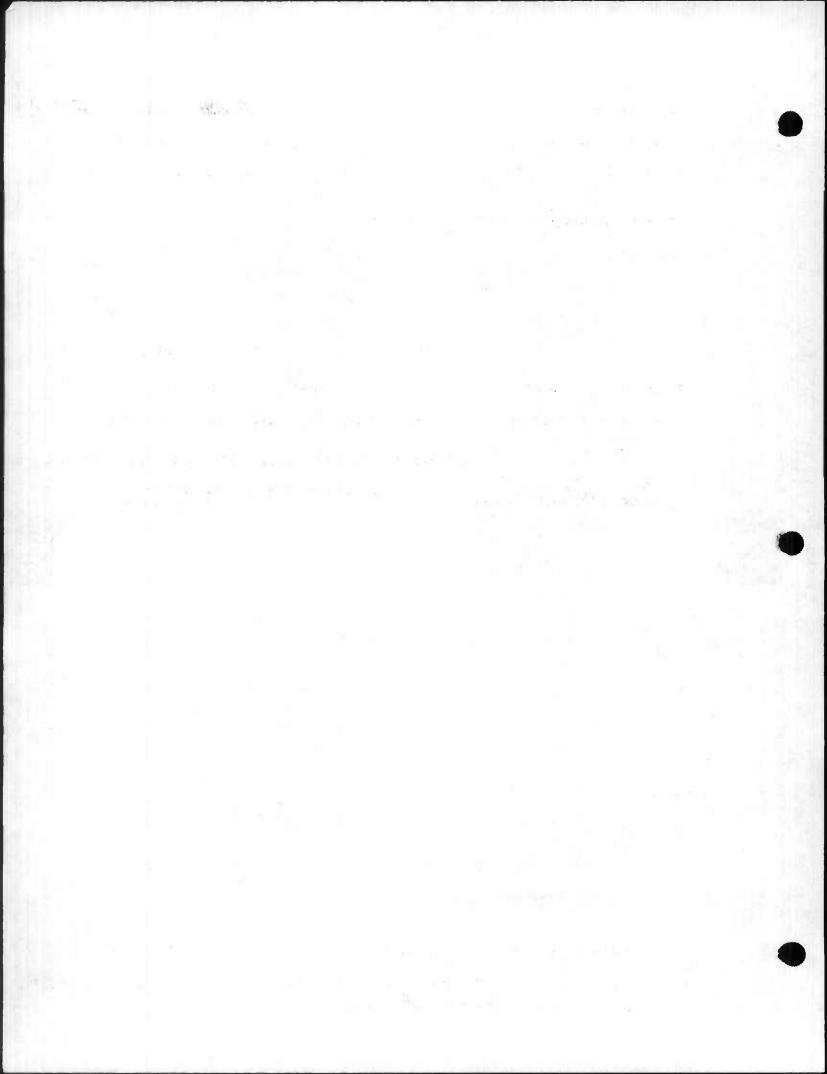
The law requires that the death certificate be executed signed by the a d be detached f been signated cartificate has b irector, paga 2 s or Attending Physician: this After death. Director: / in 24 hour.
The Funeral Direction by

Registra



State of Maryland / Department of Health and Mental Hygiene

					Ce	rtifica	ate of	Death		Reg. No.	tell and	10116	
huciaian		1. Decedent's Neme (First, Middle,	Last)						2. Dete of D	eeth Day	Vons	3. Time of Deeth	
hysician Medical/		Joyce Elaine Hi							MARCI	H 19	1999	10:55 A	
Examiner		e. Fecility Neme (If not institution, g	rive street end numbe	r)				4b. City, Town, o			unty of Death	ensi	
		16611 Mosby Driv						William			hingto	n	
uneral rector		215-42-3338	Sex 7. / 1 ☐ M 2 ☑ F	lge (In yrs. 55	lest birthday) Yrs.	. Month	der 1 Year s Deys	If Under 24 Hr Hours Min		irth ley, Year) 1,1943	9. Births Cour Mary	plece (Stete or Foreig htry) land	
B	-	Usuel Residence of Decedent 10e. State 10b. County		10c Ci	ty, Town or Le	ocation						od toolde On their	
notified at Inector			+		•						1	1 ☐ Yes 2 ☑ No	
ect ett	5	Maryland Washing	JTON	WI	lliams	-							
r Items 23s or 25s-f s niner must be notified Funeral Director		16611 Mosby Drive					Zip Code 21795	5		USA	of Whet Cour	ntry?	
Exan by	2	1. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes	? No				fispenic Origin? (en, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		Race - Americ Bleck, White, ecity: Wh		
Completed		15. Decedent's (Specify only highest of	Education		16e. Dece	dent's Us	sual Occup	etion during most of w	orkina	16b. Kind o	of Business/Inc	dustry	
al ol		Elementery/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT	use retired	d)	VIKING				
O Lo	5	12			Owne	r				Weddi	ng Con	sultant	
e = e	1	7. Fether's Name (First, Middle, La	st)					18. Mother's Na	er's Name (First, Middle, Maiden Surneme)				
marked martic s		Theodore Martin	Myers					Helen	Irene Ma	rshall			
arms arms		19e. Informent's Neme/Relationship			19b. Maili	ng Addre	ss (Street	end Number or F	Rurel Route Numi	ber, City or To	wn, Stete, Zip	Code)	
12		George F. Hill/H	lusband		1661	1 Mo	sby [Drive W	illiamsp	ort, MD	21795		
a de	2	0e. Method of Disposition			Pleca of Dispo	osition (N	eme of	no.i	Dete	20c. Location	on - City or To	own, Stete	
4 1		1 ☐ Burlat 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removel from State	9		-			13 1000	Smith	chura	Maryland	
mportant: iny injury 2008.		21. Signeture of Funeral Service Lic	1 1	51111				ss of Facility	12,1333	3111111	soul g,	mai y rand	
any is		Majon 1111.	ald					uneral H				eague St. D 21795	
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edical	t	Sequentielly list conditions, feny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury hat Initiated events esulting in deeth) Lest	c	Due to (o	r es e conseq	uence of):						
an/M			d										
S S S S S S S S S S S S S S S S S S S	P	ert II. Other significent conditions	ulting in the u	cause giv	en in Pert I.	23b. Did	tobacco use	contribute to	the cause of death				
signed by the ettend do be detached for us.									1	Y00 2⊠N	lo 3□ Prot	bably 4 Unknow	
hou hou									24e. Wes	s en eutopsy ormed?	eve	ore eutopsy findings eilable prior to mpletion of cause deeth?	
Dege Co									10	Yes 2 ₽10	0 10	Yes 2□ No	
, T		5. Wes case referred to medical						26. Piece of De	eth (Check only	one)			
tor to		exeminer? 1 ☐ Yes 2 ☐ No	Hospitel: 1 ☐ Inpat	ient 2 🗆	ER/Outpetier	nt 3 🗆 🗈	Oth Oth	0.00	Home 5 ☐ Res		Other (Specifi	el .	
director, page 2 s		7. Menner of Death	28a. Dete of Inj (Month, D		28b. Time of		28c. Injun Wor		28d. Describe			·/	
				ey Yeer)	Injury	м							
		1 ☐Naturel 5 ☐ Pending investigation	2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factor building, etc. (Specify)										
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edical Certification: T	2	2 Accident 3 Sulcide 4 Homicide 9a. Certifler (Check only one) 9b. Signature end title of cartifler	28e. Placa of Ir building, e hysicien: To the best miner: On the bests end menner s	of my kno of exemine leted.	wledge, deeth tion end/or Inv	occurre vestigatio	d et the tim n, in my op 9c. License	pinion, deeth occ e number	City or To	ceuse(s) end date end place 29d. Date sig	ca, end due to gned (Month, i	the ceuse(s) Dey, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 1999 4c. County of Death Holmes Bertha 4b. City, Town, or Location of D 4a Facility Name (If not institution, give street and number) Washington Washington County Hospital Hagerstown Hours Min. 8. Dete of Birth (Month Pey, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 1□M 2□F Months Deys Yrs. 220-18-0180 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 A N. Jonathan Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1X Never Merried 2 ☐ Merried Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hotel Cook 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Elizabeth (Unknown) James Holmes 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Guardian 9 Public Square Hagerstown, Maryland Charlene Lloyd 20e. Method of Disposition 20b. Ptace of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Rose Hill Cemetery 3/12/99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signeture of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) 2 wks neumonia Due to (or as a consequence of): Zwks 1119+10n Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Dementia YEARS Due to (or es e consequence of): Senilly Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Gangrene both feet 24b. Were autopsy findings available prior to 24a. Wes en eutopsy Periphral Vascular Disease completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturat 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Physician/Medical been signed by should be detac by Completed certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medicai Certification: To

Physician

/Medical

Examiner

Director

Funeral

Funeral

Director

'netural', or items 23s or 28s-f

Hygiens. ther then

permit. Pages 1 and 2 should be the Department of Health and Mental Hy, important; if them 27 is marked other any injury or other

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

25.	Was case referred to medical examiner?	
	1 ☐ Yes 2 No	
27.	Menner of Death	

5 Pending investigation 6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

MD 217/3

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certified

29c. License number

BOONSBORD

29d. Dete signed (Month, Day, Year) March 10, 1999

State

Registrar

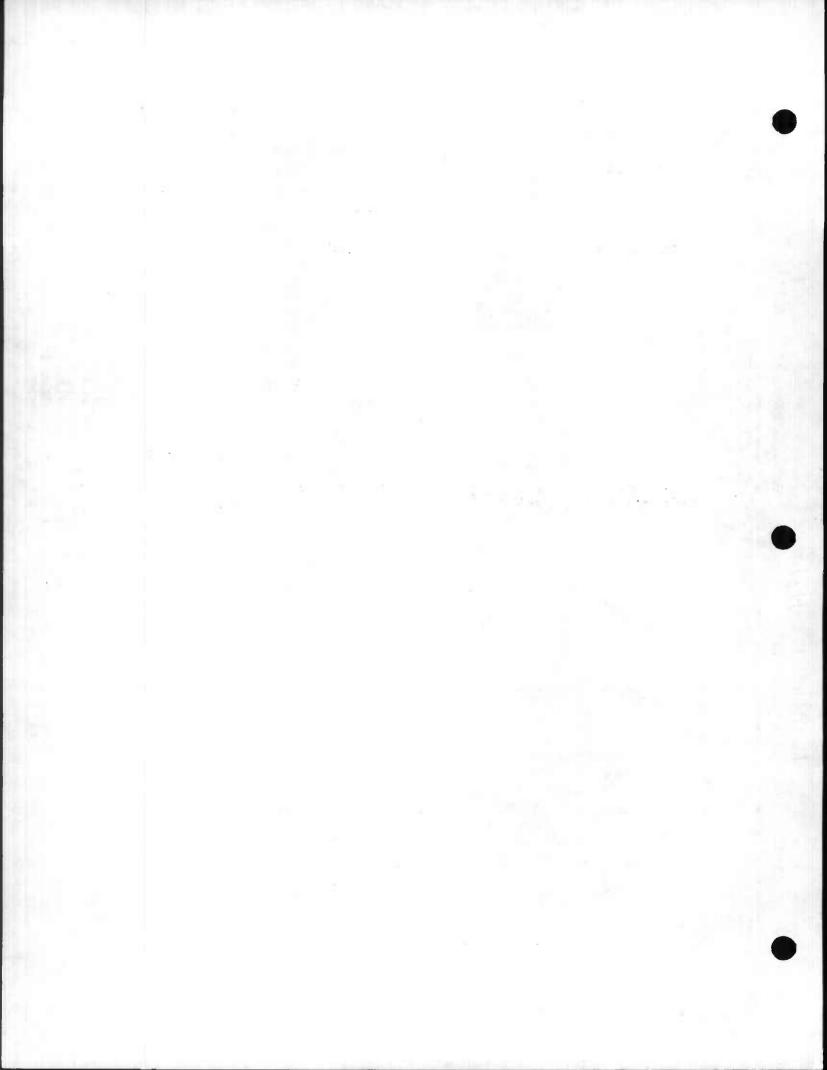
ZAFAR MALIK 31. Date filed (Month, Dey, Year)

32. Registrer's Signeture 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

2AFAR MALIK 20511 LAPPANS R)

MD



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year March 20, 1999 Margaret 6:55 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 M 2 KF Months Yrs. 213-18-4089 5-17-19 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Snow Hill Md. Worcester 1X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 508 S. Church Street 21863 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married Married I ☐ Yes 🗶 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Worcester County Elementary/Secondary (0-12) College (1-4or 5+) Food Service Board of Education 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Snow (Mabe) Charles Thomas Mabe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John D. Hill,)son) 6828 Apache Lane, Snow Hill, Md. 21863 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/99 Snow Hill, Md. Bates Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 87 Snow Hill, Md. 21863 Dennis Funeral Home, Snow 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy 2 No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Herna 23a or

daeth

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or then any Injury or other traumatic event, the percentage of the per

the Medical Examiner must be notified at

Director

Funeral

p

Completed

Be

Examiner the burial-transit and attending physician for use es the buria à signed t certificate this

Box 68760

Division of Vital Records, P.O.

Physician/Medical p Completed Be 2 Certification:

2 Accident

4 ☐ Homicide

3 Suicide

o the Hospital or Attending Philibin 24 hours after death.
o the Funeral Director: After this ompletely filled in by the funeral completely within 2

> State Registrar

Medical

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier NO.

29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

21804 1104 Healthway Dr., Salisbury, MD Michael R. Atkins, M.D.

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registrar's Signature R 25

1 ☐ Yes 2 ☐ No

CEE & S

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2010 6. Hudson 222-09-2850

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 1818 HAROLD E. HUDSON MANCH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth WICOMICO Examiner SALISBURY PENNINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Devs Hours Min. (Month, Dey, Year) 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** 1MM 2□ F 222-09-2852 Yrs. Director 11-06-1919 SELBYVILLE, DE Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No SUSSEX DAGSBORO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? RD#2 BOX 31 Funeral 19939 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 HNo Specify: Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ages 1 and 2 should be filed within of Health and Mental Hygiene. It if Ihem 27 is marked other than " yor other traumatic event, I're Men Elementery/Secondary (0-12) College (1-4or 5+) FUEL OIL DELIVERY MAN 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHN E. HUDSON DONA M. EVANS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) PATSY H. DENNIS/ DAUGHTER 5079 WHITE MARLIN DRIVE, EDEN, MD. 21822 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Pages nent of h 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State ROXANA CEMETERY Qther (Specify) ROXANA, DELAWARE 21. Signature of Puneral S 22. Name end Address of Fecility MELSON FUNERAL 43 THATCHER ST, THATCHER ST, FRANKFORD, Do not enter the mode of dying, such es cerdiac or respiretory errest, at only one ceuse on each line. Approximete intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel S'UPPEN DEATIK disease or condition resulting in death) Examiner Examiner PRRYTHM IND.

Due to (or es e consequence of): that the death cartificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest CONGESTIVE LARPIONYO PARTY Box 68760. Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ► ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29e, Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

DENNIS J. Chuchick, mo 400 EASTERN Shore Un SAlisbury Md. 21804

32. Registrer's Signeture

Registrar

State

31. Dete filed (Month

30. Name end eddless of person who completed cause of deeth (Item 23e) (Type, Print)

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and the second s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Warch **Physician** 00:35 ROLAND **JAMES** JORDAN /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) MAY 29, 1922 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) NEW YORK 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Yrs 76 085-16-6799 Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 7130 WHEELER ROAD U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1942If Yes, Give Year or Dates: 1946 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be tiled within 72 hours effer d Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event, its landers. Black, White, etc. 1 ☐ Never Married 2K Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC PAPER PRODUCTS MANUF. 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) FREEMAN JORDAN MILDRED SIMMONS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) MARY R. PALMER/DAUGHTER 7130 WHEELER ROAD, BOONSBORO, MARYLAND 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 3/19/99 BOONSBORO, MARYLAND 21. Signature of Funeral Service Liperage 22. Name and Address of Fecility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) AINO MUSAY Examiner Due to (or as a consequence of): Examiner physician end s the buriel-transit thet the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 Yee 2 No Completed by 24b. Were eutopsy findings eveileble prior to 24a. Was an eutopsy performed? peen s completion of ceuse of death? certificate hes 2 1000 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Yes 2 No deeth. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the

P.0. Division of Vital

Jordan, Roland James

State Registrar

Medical

29b. Signeture end title of certifier

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piace, end due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MEGCALLAMPYHA

A 20

9 1999

6 Could not be determined

3 Sulcide

29a. Certifier (Check only one)

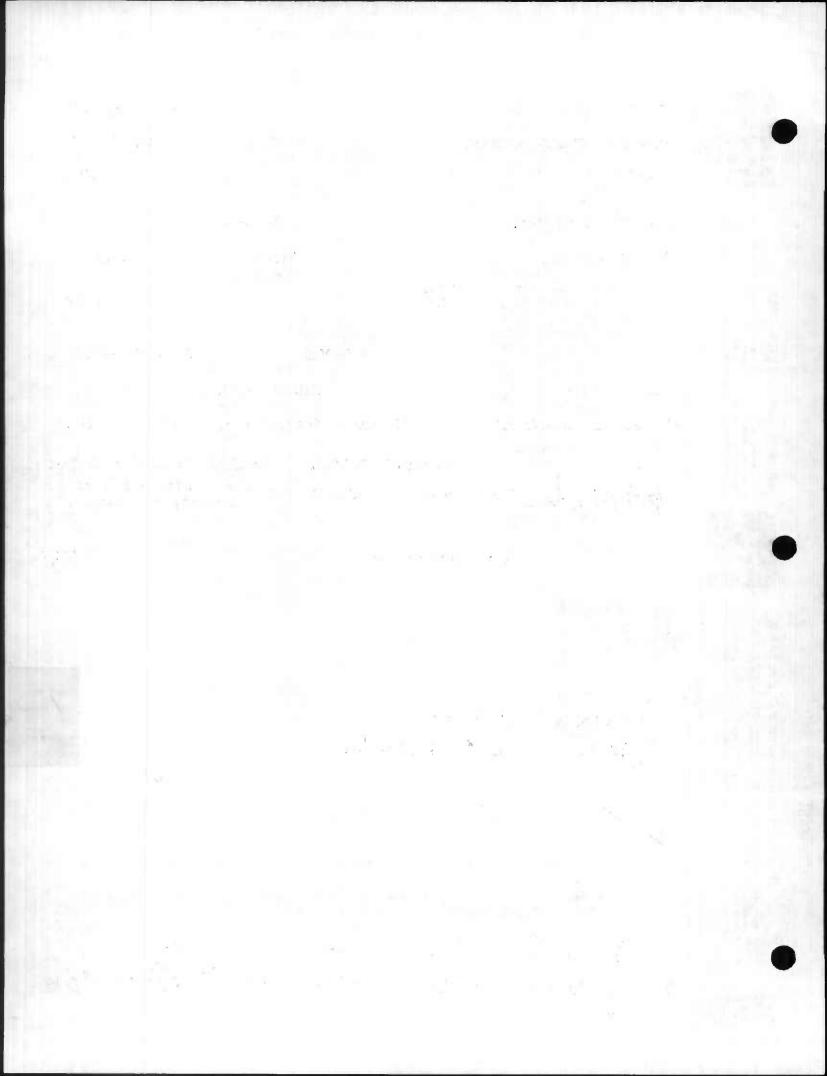
4 Homicide

31. Date filed (Month, Day, Yeer)

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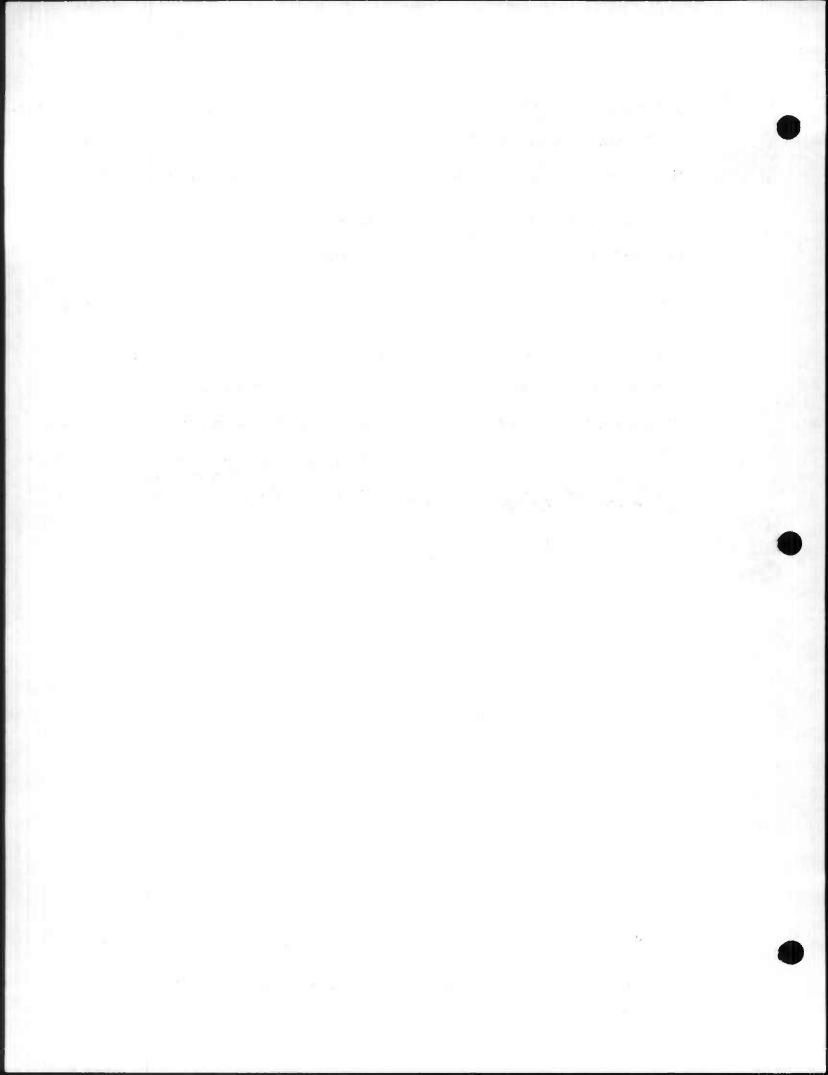


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Dey 1999 Helen Louise JOHNSON 12:44 a.m /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Avalon Manor Nursing Home Hagerstown Washington 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 □ M 2 🖾 F Deys Hours Yrs 88 Director 218-05-7548 Oct. 28, 1910 Maryland Usuet Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? with 19614 Old Forge Road Funeral 21740 USA death 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give Year or Dates: Was Decedent of Hispanto Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ò 3₺ Widowed 4 Divorced Specify white Completed 16e. Decadant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within 7;
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, fine Meda. Elamantary/Sacondary (0-12) College (1-4or 5+) 12 housewife her own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Clarence Jack Williams Emma Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rebecca Williams - daughter 14015 Village Mill Dr., Maugansville, Md. 21767 altimore, 20e, Mathod of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1X Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery 3-22-99 Hagerstown, Maryland 21. Signatura of Fuseral Service Licenses 39. Name and Addrass of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Onset end Death **Physician** /Medical tmmediate Ceusa (Final diseese or condition resulting in death) Arterio relente Cardionnales somen Examiner Due to (or es e conseguenca of) Examiner physicien and s the buriel-transit Sequentietly tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseesa or Injury that Initiated events rasulting in deeth) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of): ettending p P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert It. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Heart consentin Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen Senie Demente 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case raferred to medical 26. Pleca of Daeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 LHo Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. tnjury et Work? 1 Alatural 5 Panding To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of tnjury - At homa, ferm, street, fectory, offica building, etc. (Specify) 4 Homloida cal 29a. Cartifiar 1 Certifying Physictan: To tha best of my knowledga, daath occurred at the time, dete end plece, and dua to the ceusa(s) and mannar as stated. 2 Medical Examiner: On the basis of exeminetion end/or Investigetion, In my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end mannar stated. P 29b. Signeture end titla of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) tona mo D18017 march 18, 1275 30. Neme end eddrass of person who complated causa of daath (Itam 23a) (Type, Print) Dr. Vasant Datta, 334 Mill Street, Hagerstown, MD 21740 31. Deta filed (Month, Day, Yeer) 32. Pagistrar's Signature State oaks MAR 1 9 1999 Registrar

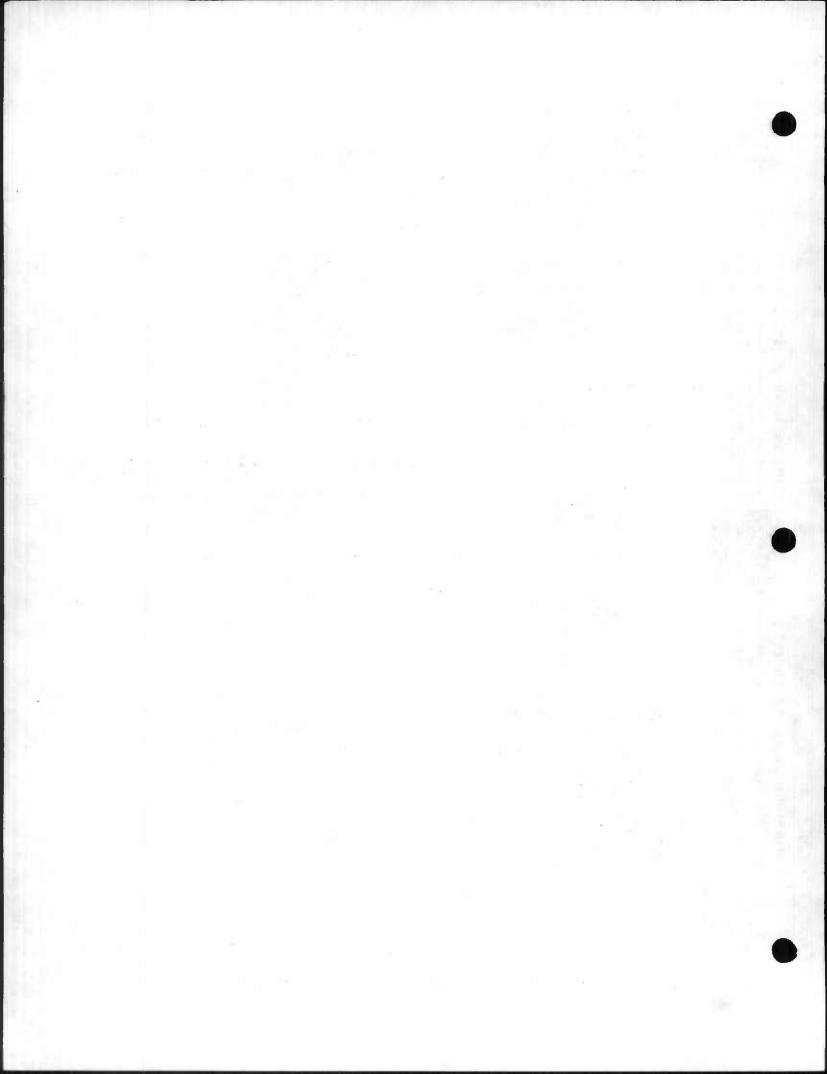
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death Reg. No. 99	1718
	1. Decedent's Name (First, Middle, Last) 2. Data of Death 3	3. Time of Death
Physician /Medica	Bruno Christian JENSEN MARCH 11, 1999	7:00 AM
Examine	4e Facility Name (If not institution, give street and number) RAVENWOOD LUTHERAN VILLAGE 4b. City, Town, or Location of Death 4c. County of Deeth WASHINGTON	
Funeral Director	5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplect Country) 1 Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) 1 Usual Rasidence of Decedent	a (State or Foreign k
yand yand		Inside City Limits
e Men	Maryland Washington Hagerstown	1 Yas 2 □ No
o 28	Maryland Washington Hagerstown 106. Street and Number 107. Zip Code 109. Citizen of What Country's	?
23a		Indian
020 urs s	185 Summit Avenue 21740 U.S.A. 1. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Sive Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lif Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Reca - American Bleck, Whita, etc. 15. Yes, Specify: White	
15-002 72 hours	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) 16b. Kind of Business/Indust (Give kind of work done during most of working	try
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and 212. The filed within his Hygiens. India Hygiens. India other than event, the H		
should be and Mental marked o	Hans Peter Jensen 18. Mother's Name (First, Middle, Maiden Surneme) Julia Maria Madsen	
Maryian d 2 should b th and Ments 7 is marked traumatic or	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Co	ide)
	Alice L. Jensen - Wife 1158 Luther Drive Apt. 41 Hagerstown, Md.	21740
altimore, Imir. Pages 1 an partment of healt portent: If New 2' y Injury or other 28.	20a. Method of Disposition 1X Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) Rest Haven Cemetery 3/15/99 Hagerstown, Magnetic Rest Rest Rest Rest Rest Rest Rest Rest	
Baltimol permit. Pages Department of Important: If it eny injury or once.	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryla	
ficate be executed ficate be executed g physician and as the burial-transit grant framing fram	Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Due to (or es e consequence of):	year
2 2 2	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the large of the la	
d to the second	a control of the cont	eutopsy findings lible prior to letion of cause
	o Nam are	eth? ′es 2□ No
of Vital F Physician: The this certificate rai director, pag	25. Was case referred to medical examiner? 1	
Druno C Division of Vita To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director. After this certific complately filled in by the funeral director, Medical Certification: To Be		
Division of the form of the fo		
To the Hospital within 24 hours at To the Funeral complately filled Medical Co		e cause(s)
To the To the comple	29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Detection) 29d. Dete signed (Month, Detection) 29d. Detection of the signed (Month) and the sign	y, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDSON MOODY MD. 1190 MT. AETNA RD., HAGERSTOWN, MD. 21740	
State	31. Dete filed (Month, Day, Year) 32. Registra's Signature 9. Sports	

DHMH 16 Rev 6/95

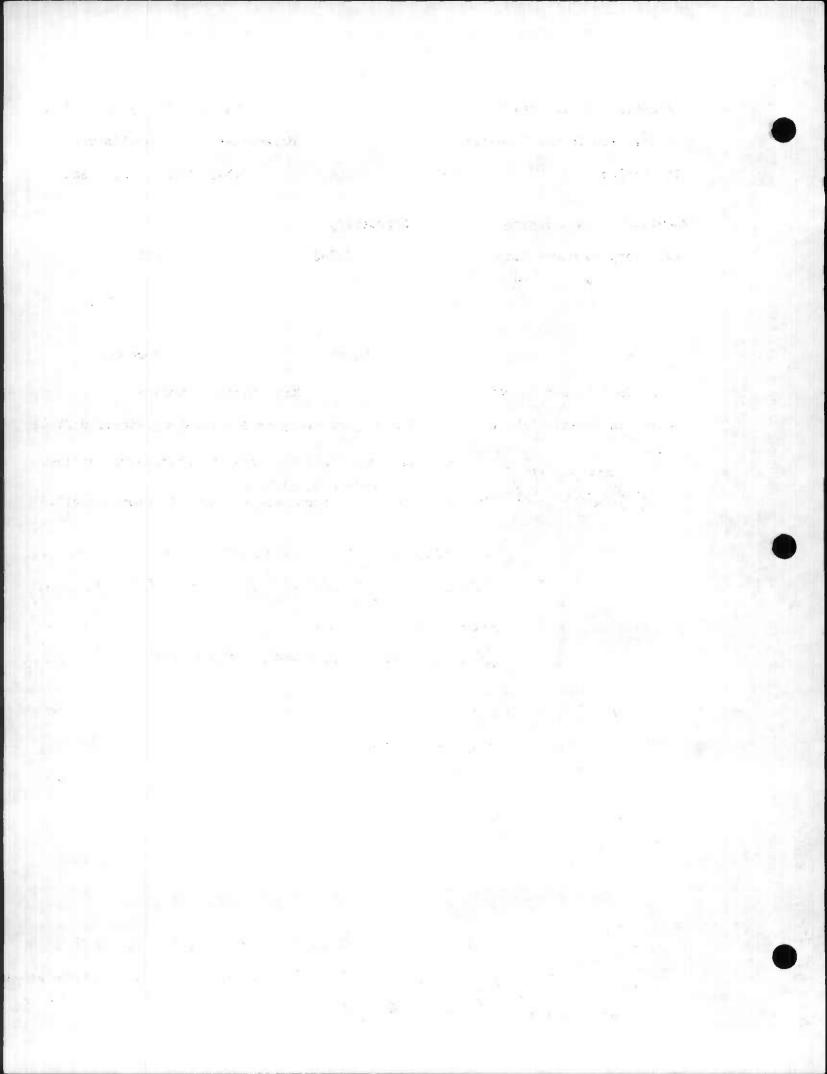


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0115 Francis Wilbur Knight 1999 March 18 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Months Days 81 Director 216-14-6305 Feb.5, 1918 Maryland Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d foslde Clty Limits to or 28a-f show 10b. County 1 Yes 2(XNo Directo Maryland Washington Sharpsburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itams 23a 2402 Harpers Ferry Road 21782 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Clerk Government marked other permit. Pages 1 and 2 should be filed. Department of Health and Menter important: If item 27 is any injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Christopher Knight Mary Helen Crampton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Whylmenia M. Knight/Wife 2402 Harpers Ferry Road Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) 3-21-99 Sharpsburg, Maryland Samples Manor Cemetery 21. Signature of Puneral Serv 22. Name and Address of Facility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795 Approximete Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bean fullure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical 8 art Failure 23b. Dfd tobacco use contribute to the cause of death? Pert fl. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. Scherosis 3 □ Probably 4 Unknown ă 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy 08062 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To SE SE 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? 28a. Date of fnjury (Month, Day Year) 1 Satural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide 6 12 Certifying Phyeicfan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier edical To the Ho within 24 to To the Fu 29d. Date signed (Month, Day, Year) 29b. Signeture and title of confidence 29c. License number

ath (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar 31. Dete filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Q Q 1 0 7 2 0

					Cei	rtifica	te of	Death		Reg. No.	n 10	120
Harlin.		1. Decedent's Neme (First, Middle, I	.ast)						2. Dete of De	eth		. Time of Death
Physic /Med		Elizabeth F	. Kellv						Month 03	12 19	Yeer 199	8:00 PM
Exami		4a. Fecility Neme (If not institution, g		r)			4	b. City, Town, or				0.00 11
		512 Walnut Stree	+					Pocomoke	City	Morco	ctor	
Funera			Sex 7. A	ge (In yrs.	last birthday)		r i Year	If Under 24 Hrs.	8. Dete of Bir	Worce		(Stete or Foreign
Director	_	220-32-0958 Usuel Residence of Decedent	10 M 20 F	9)4 Yrs.	Months	Deys	Hours Min.	8. Dete of Bir (Month, De 02/06)	1905	Maryla:	nd
Aaryland F ahow	jo.	10e. Stete 10b. County			y, Town or Lo							inside City Limits
the A	Directo	Maryland Worcest	er	POC	comoke	-	. 0. 4.			40. 00.		
A S	à	Toe. Streat end Number				10f. ZI	p Code			10g. Citizen of \	Whet Country?	
ath value	rai	512 Walnut Stree				_	1851			US		
illed within 72 hours after death with the Maryland Hygiene. The than "natural", or frems 23a or 28a-f show out, the Mexical Experience must be inclified at	by Funeral	11. Maritel Stetus 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 Yes 2 4 If Yes, Give Yeer or Dates:	? No	1	f Yes, spe	city Cube	lispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American i ck, White, etc. " white	
o p		15. Decedent's	Education		16e. Deced	dent's Usu	ei Occup	etlon		16b. Kind of B	usiness/Industr	rv
7 2 2	Completed	(Specify only highest g		* 1	(Give	kind of wo	ork done i ise retired	during most of wor	rking			•
the the	E	Elementary/Secondery (0-12)	College (1-4or	5+)		tici				Poputu	Chan O	.more
be filed within the Hygiene.		17. Fether's Neme (First, Middle, La	st)		Dear	ICICI	au	18. Mother's Nar	ne (First, Middle,	Beauty Maiden Sumen		MIET
S d d S	Be		•								,	
2 should by end Mente is marked	2	O. F. Reid			101 10 11			Laura M				
d 2 should th end Mer 7 is marke traumatic		19e. informent's Neme/Reletionship						end Number or Ru				10)
		John W. Kelly (g	randson)	1				Rd., St				
T To T		20e. Method of Disposition 2 ☐ Cremetlon 3	□Removel from State		Piece of Dispo cemetery, cres	sition (Ne netory or	me of other plea	ce)	Dete	20c. Location -	City or Town,	Stete
Pag nent int: h		4 Donetion 5 Other (Spec		1	nany Meti	mdist	Cleme	terv 3	/17/99	Pocomol	ce City	, MD
permit. Pages 1 en Department of Heel Important: If item 2 any injury or other		21. Signeture of Juneral Service Lic	ensee					ss of Fecility	1 1122	100011103	ic orej	1.10
Depa limpo		Pril 1 ADe	an moll	29	Ho	llow	ay-M	elson Fu	neral Ho	me, P.A		
_		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	maliantina that accord	, d sh = d = s	10	3 Li	nden	Ave., P	ocomoke	City, M	D 2185	1 proximete
death certificate be executed death certificate be executed e ettending physician and ad for use as the buriel-transit	ai Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DEN- b. FAI	LUR	PATT or es e conseq or es e conseq	0	TH	RIVE				
eath certificete ettending phys for use as the	an/Medical	thet initiated events resulting in deeth) Lest	d	Due to (o	r es e conseq	uence of):						
de est	sicia	Pert ii. Other significant conditions	contributing to death	but not res	ulting in the ur	ndertying	cause giv	en in Pert i.	23b. Did	tobacco use co	ntribute to the	cause of death
het the od by th detech	by Physician/									Yes 2□ No	3 Probabl	
aw requir	Completed b								24e. Wes	en eutopsy rmed?	evaliet	eutopsy findings ble prior to etion of cause th?
The late he page	No.								10	Yes 2 No	1 □ Ye	s 2 No
iclan: The	0	25. Wes case referred to medical						28. Place of Dec	eth (Check only o	one)		
Physician: this certific	To B	examiner? 1 ☐ Yes 2 No	Hospitel:	ient 2 🗆	ER/Outpetien	t 3 D	OA Oth		10	dence 8 Oth	er (Snecity)	
Physical		27. Menner of Deeth	28a. Dete of Inj	ury	28b. Time of		28c. Injur			how injury occur		
or Attending effer death. Director: Affer din by the fune	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Sulcide 6 Could not	on (Month, Di	ay Year)	Injury	М	10	k? Yes 2 No				
tal or Attend rs efter death al Director: /	Certif	4 Homicide determine	d 250. Piece of in	ijury - At h		eet, tector	у, опісе		City or To	Street and Numb vn, Stete)	er or Hurai Ho	ute Number,
To the Hospital or Attending Within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	edica	29a. Certifier (Check only one) Certifying F	Physician: To the best aminer: On the basis of end menner s	of exemine	wledge, deeth tion end/or inv	occurred	et the tin	ne, dete end plece pinion, deeth occu	, end due to the rred et the time,	cause(s) end ma date and piece,	anner as stated and due to the	i. cause(s)
To the He within 24	ž	29b. Signature and title of certifier	^		-	29	c. Licens	e number		29d. Dete signe	d (Month, Day	Year)
FSFO		1 0	1	1			Dr	2556		2-1	0-50	
)		17	tax 1		>		~ C	2776		2 '	8-59	
	1	30. Name and address of person was	yompleted cause br	death (iteñ	n 23a) (Type,	Print)						
	V		tiano - 10	0 Eic	hth St	reet	Po	comoke C:	ity, MD	21851		
St	ate	31. Dete filed (Month, Dey, Year)	1000 32. Regist	rer's Signe	ture 4		20. 6	11	-1,			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					viaiyiai		tificate of	Death		Reg. No.	9	10721
Physic		1. Decedent's Nam- RICHAE		est)		LOWE			2. Date of De Month MARCH	Dey 18, 199	Year 99	3. Time of Death 5:55 PM
/Medi Examir				ive street and numb	er)			4b. City, Town, or				3,33
CAUTIN	101	Salisbury	Center	; Genesis	Elder	Care		Salisbu	cv, Md.	Wie	comic	30
Funeral Director		5. Social Security N 399-26-	1umber 6.			7 1 Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs				elece (State or Foreign try) D. C.
deeth with the Maryland ms 23s or 28s-f show great be notified at		Usual Residence of 10a. State	10b. County		10c. Ci	ity, Town or Loc	cation		18		1	Od. Inside City Limits
the Mar 28s-f al	cto	MD.	WORCES	STER	00	CEAN C	ITY					Yes 2□No
or 22	- Si	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of \	What Coun	try?
23 v	a	12024 0	CEAN GA	ATEWAY #	21		21842	2		U.S	. A .	
3 2 2	by Funeral Director	11. Merital Status 1 ☐ Never Merri 3 ☐ Widowed	ied 2 Merried	12. Wes Decede Armed Force IX Yes 2 If Yes, Give Year or Date	is? ⊒No /\./		Ves Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	ck, White,	etc.
21215-0020 a within 72 hours of piene.	Completed	(Spec	15. Decedent's l			(Give I	ent's Usuel Occu kind of work done O NOT use retire	during most of wo	rking	16b. Kind of B	usiness/Ind	fustry
2121 d within giene. r then "	E O	1 7	noary (0-12)	College (1-44	or 5+)	Р	AINTER			CONST	RUCT	ION
	Bec	17. Father's Neme	(First, Middle, Las	st)	- 0			18. Mother's Ne	me (First, Middle	, Maiden Suman	10)	
arylan should be nd Mental marked o	ToB	JOHN	W. Lo	OWE				MILI	DRED L	NKNOWN		
Maryland 2 should be file h and Mental Hy I a marked othe traumatic event		19e. Informent's Ne	eme/Relationship	(Type, Print)		19b. Meiling	Address (Stree	t and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)
nore, ges 1 an it of Heeli if item 2 or other			oosition Cremetion 3	☐Removal from Sta	te		sition (Name of natory or other pla		Dete	OCEAN 20c. Location -		own, Stete
timent thant: blury o			5 ☐ Other (Spec	**	S	-	RY CREI	-	3-20	SALISB	URY	MD.
Baltimo permit. Page Department of Important: If any Injury or page.	W	21. Signature of Fu	us }. /	Durmeile	· Dr.		Name end Addr	FUNERAL	HOME	BERLIN	, MD	. 21811
Certificate be executed from and ding physician and ding physician and assess the buntal-transit	VMedical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, imediate rhying injury	b. CA c	Due to f	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or	enge of):	neon	estan	erary d	la	y yn.
Box death certi	clar								1			
O. o	Physician/M	Pert II. Other signif	icant conditions	contributing to death	but not res	sulting in the un	derlying cause g	iven in Pert I.				the causs of death? bably 4 Unknown
cords,	Completed by								24a. Was	en eutopsy ormed?	av.	ere eutopsy findings aileble prior to mpletion of cause death?
The lew	E								10	Yes 2□No	15	☐Yes 2☐ No
	Be	25. Wes case refer	red to medical					26. Plage of De	eth (Check only	one)		
of Vita Physician: this certific	To	examiner? 1 Yes 2	No	Hospital: 1 Inpe	atient 2	ER/Outpatient	3 DOA	ther: 42 Nursing I	lome 5 ☐ Res	dence 6 Oth	ner (Specif	(ע
Affect fune	Certification:	27. Manner of Deatl 1	5 Pending investigati	on he	Day Year)	28b. Time of Injury		Yes 2 No		how injury occur		
Divi	Certif	4 ☐ Homicide	determine	d 268. Place of	Injury - At h etc. (Speci	iome, ferm, stre	el, factory, office			Street and Numb wn, State)	ber or Rura	al Route Number,
Division To the Hospital or Attent within 24 hours after dealt To the Furerel Director: completely filled in by the	edicai	29e. Certifier (Check only one)	1 Cortifying P 2 Medical Exa	hysician: To the be uniner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred et the t estigation, in my	ime, date end plece opinion, deeth occi	e, end due to the urred et the time,	cause(s) end me date end plece,	enner es s end due to	teted. the ceuse(s)
To the Within 2 To the comple	Ž	29b. Signature end	litle of certifier	11	11		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
		1	//	NVH		_	D-	-29349		31.	9/0	>
		30. Name and adde	ass of narenn who	completed cause of	f death /Ites	m 23e) (Tuno E				41	41	
	2			M.D., 110				CDITOV M	0 2100/		/ /	
Sta Registr	te	31. Dete filed (Mont			Strer's Sign		Soon	SBURIT M	D. 21804			

- was in the state

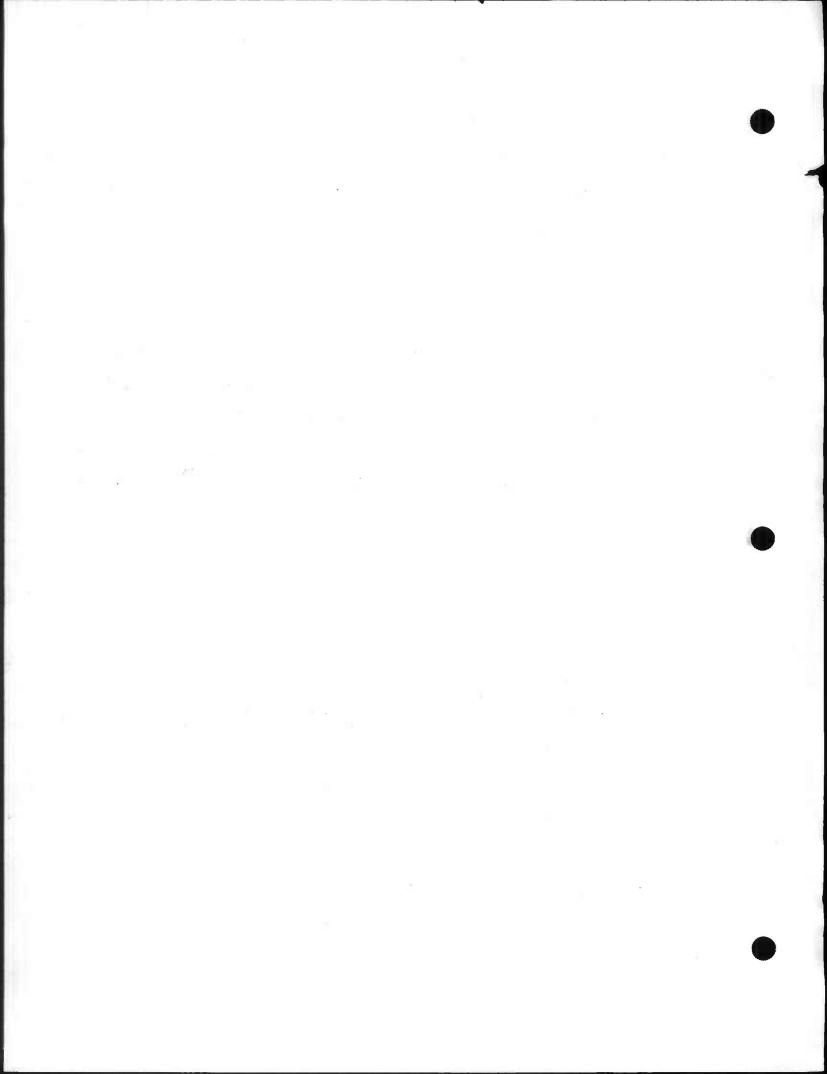
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

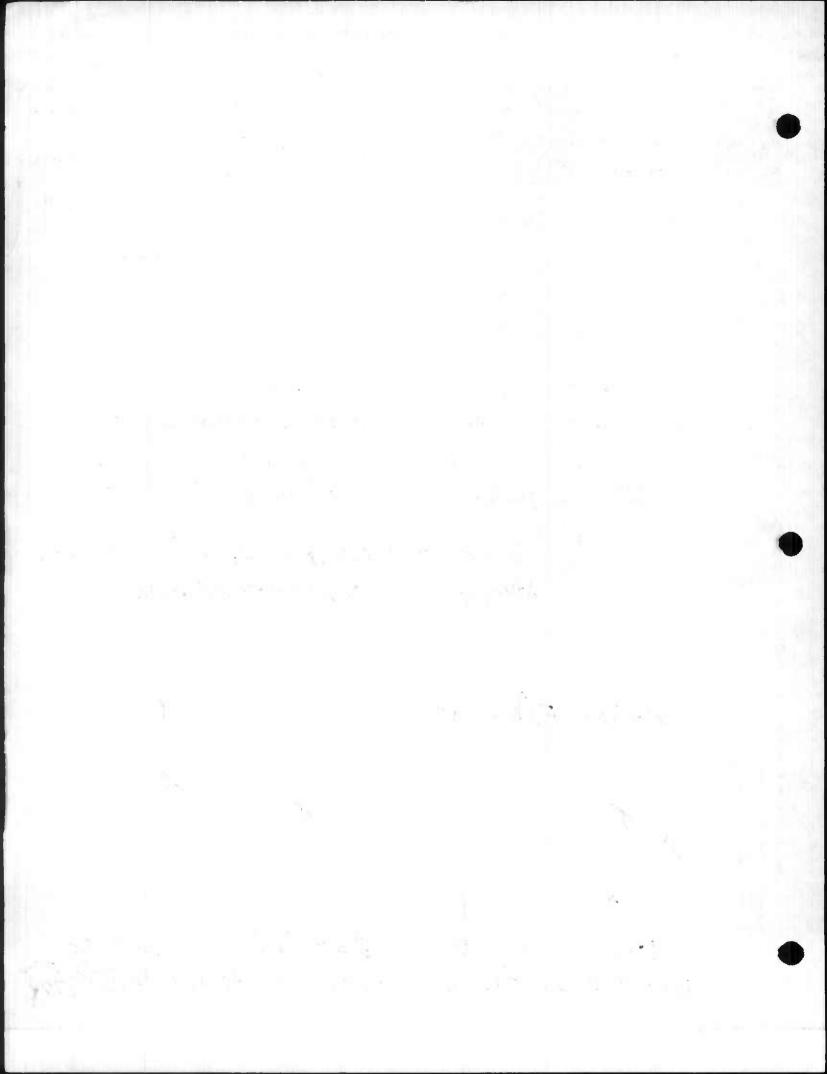
	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPART			MENTAL HYGIEN	E	1 400 8. 2.
	1. DECEDENT'S NAME (First, Middle, Last) Debra Ann	McCAULEY				2. DATE OF DEATH MONTH 13,	"1999 ^{YE}	3. TIME OF DEATH 9:20A _M
	216-76-3505	M 2 🖾 F	41 YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Ybar) Aug. 8, 19	957 8. B	IRTHPLACE (State or Foreign ountry) (aryland
TOR	9e. FACILITY NAME (If not institution, give street a 314A Key Avenue	and number)		Hager	S town	EATH	Wash:	ington
DIRECTOR	10a. STATE 10b. COUNTY Maryland Washin	gton		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1XXYES 2 NO
FUNERAL	314A Key Avenue			101	21740		10g. CITIZEN (A.
В	1 Never Married 2 M Married	WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE	≥ ⊠NO	If yes, spe	ENDENT OF HISPAI ecify Cuban, Maxica 2 X NO Specif	NIC ORIGIN? (Specify Yas an, Puarto Rican, atc.)		RACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) Co	ON 16 bileted) 16	e. DECEDENT'S US (Give kind of wor life Do NOT use homema	rk done during mo: retired.)	N st of working	her ow	n home	w
BE COM	17. FATHER'S NAME (First, Middle, Last) John W. Sn		Tollicine	KC I	18. MOTHER'S NA	ME (First, Middle, Maiden Nancy Lee	Surname)	gham
TO B	19a. NFORMANT'S NAME (Type/Print) Mr. Danny McCauley/	husband	19b. MAILING A 314A K	odress (Street a ey Aven	ue, Hage	Route Number City or Town	n, State, Zip Code 1ryland	21740
8	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal 1 4 Donation 5 Other (Specify) 21. SIGNATURE OS PURERAL SERVICE LICENSE	from Stata cemeter RO	ACE AND DATE OF	Cemete:	ry		agerst	own, Maryland
	Scottm	Nemue	D.	415 Ea		on Blvd., H	lagerst	ral Home own, Maryland 21740
	23. PART I. Enter the diseases, or companies shock, or heart feilure. List IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	DUE TO (OR AS A CO	iline.			h as cardiec or respi	ratory arrest,	Approximata Interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A CO						
MEDICAL (PART II. Other significent conditions co	ntributing to death but	not resulting in	the underlying	cause given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN:	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NTRIBUTE TO C		26. PL	YES NO			
BY PHYSICIAN:		Inpetient 2 ER/Outpetie 26e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 26c, INJ		6 Other (Specify) 28d. DE\$CRIBE HOW IF	NJURY OCCURE	D
	3 Suicide 8 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, str	eet, factory, office		29f. LOCATION (Street a City or Town, State)	ind Number or Ru	iral Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On	To the best of my knowledge the bests of axamination are						ise(s) and manner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER Michael J. W.	relowek	MD		29c. LICENSE NUI	667	▶ 3.	NED (Month, Day, Year)
		Clornock	(ITEM 27) (Type, P	rine) restruct	Campus	R1 Sride	130 4	tajerstown, Ma
	MAR 1 6 1999	32. AEGISTRAR'S SIGNATU	J. A	Darks				



State of Maryland / Department of Health and Mental Hygiene

99 10723

Be Completed by Funeral Director	1. Decedent's Name (First, Middle Mary Marie) 4e. Fecility Neme (If not institution Julia Manor) 5. Social Security Number 213-68-6678 Usual Residence of Decedent 10a. Stele 10b. County Md. Wash 10e. Street and Number 23467 White 11. Marital Status 1 Never Married 2 Merr 3 Widowed 4 Divorced (Specify only highes Elementery/Secondary (0-12) 8	Miller , giva street and nu Health C 6. Sex 1 M 2 DF ington tail Rd. 12. Wes Dec Hyes, Gi Hyes, Gi Yes are re	dare Cente 7, Age (In yra last I 88 10c. City, To corces? 20 No	Yrs. Own or Loc 13. V	Smiths 10f. Zip Coda 217	Hage Hunder 24 H Hours M		13, 4c. Coun Was	y of Deeth Shingt 9. Birthol Count Mary	3. Time of Death 3:00 A.M On see (State or Fore) Cand Id. Insida City Limi 1 Yes 2 DX
Completed by Funeral Director	4e. Fecility Neme (If not institution Julia Manor 5. Social Security Number 213-68-6678 Usual Residence of Decedent 10a. Stele 10b. County Md. Wash 10e. Street and Number 23467 White 11. Marital Status 1 Never Married 2 Merr 3. Widowed 4 Divorced 15. Decedent (Specify only highes	ington 12. Wes Dec Armed F. Armed F. Armed F. Year or D. 's Education	dare Cente 7, Age (In yra last I 88 10c. City, To corces? 20 No	Yrs. Own or Loc 13. V	cation Smiths 10f. Zip Coda 217	Hage Hunder 24 H Hours M	March or Location of Death us town	4c. Coun Wax	ty of Deeth Shingt 9. Birthple Mary	ON BODE (State or Forei Cand Md. Insida City Limi
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Completed by	3. Widowed 4 □ Divorced 15. Decedent (Specify only highes	ed 1 □ Yes If Yes, Gi Year or D	2 X No		Vac conside Cul	Hispenic Origin?	(Specify Yas or No arto Rican, etc.)	14. Re	ce - Amarica	
Completed	15. Decedent (Specify only highes	Year or D	atas:	1	Tes, specify cui		into moan, etc.)		ack, White, e	
Se Completed	(Specify only highes	's Education		'	ILI TOS ZAJINO	<i>Specify</i> :		Spec	"y: Whi	te
Se Comple			16	Ba. Deced	lent's Usuel Occu	petion during most of weed)	vorking	16b. Kind of	Business/Ind	ustry
Se Cor	8	College (1-4or 5+)	life. D			orking .			
0					Homemak				ome	
100	17. Fether's Neme (First, Middle,	,					ama (First, Middla,		me)	
10	John R. Bow	man				Lilya	inn V. Br	own		
	19e. Informent's Name/Relations						Rurel Route Numbe			Code)
	Kathleen V. De	wease (Da	ughter) 2	3472	Whiteto	il Rd. S	Smithsbur	g, Md. 2	21783	
	20e. Method of Disposition	2 □Damousl from	0.000.00	of Dispos tery, crem	sition (Neme of netory or othar pla	ice)	Deta	20c. Location	- City or Tov	vn, Stete
	4 Donation 5 Other (S)	ecity)	Ringg	old (Cemeteri	Marchi	7.1999	Ringgo	eld.Md	
	21 Signature of Funeral Service I	icentee								
	Lamin:	1 No	you	Day	vis Fune	ral Home	Smithsh	raabwii	1 AUE.	2
	23a. Pert1. Enter tha diseese, or	complications that o	aused the death. Do	o not ente	er the mode of dv	ing such es card	ac or raspiratory er	rest		Approximate
edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initileded events resulting in death) Lest	- Atu	Due to (or es	e consequ	uence of):	AJ 4	Here d	1893	<	
N		d							1	
cial	Dark III Ottoral Life and Life									
ysi	Part II. Other significant conditio	ns contributing to de	eath but not rasulting	in the un	iderlying cause g	ven in Part I.				
	Atural	7/th	ellusto	>		_	_ 101	/es 2/4 No	3 Prob	ably 4 🗆 Unkno
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E									of d	aeth?
	05.14						101	es 2 No	10	Yes 2□ No
	exeminer?	Hospital:			_ 0	her				
	7	101		-	3 DOA	Nursing	_			
lo lo	1 Naturei 5 ☐ Pending	(Mon	th, Day Year)	Injury	Wo	rk?	280. Dascribe r	ow injury occi	птеа	
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	MAR I MA	April	NADI	11/	0/100	DICU	(41)1	7 200	711	11740
	edical Certification: To Be Completed by Physician/Medical Examiner	23a. Pert1. Enter tha disease, or shock, or haart failure. List of	20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from 21 Signature of Funeral Securica Licentee 23a. Pert1. Enter tha disease, or complications thete shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock, or haart failure. List only one cause on a shock or	20e. Method of Disposition Charlet Command Comman	20e. Method of Disposition Burtal 2 Commation 3 Removal from State	20e. Method of Disposition 1 City 2 Commark 2 Commerce 2 Comme	20e. Method of Disposition Disposition (Namera of Endown Place)	20e. Method of Disposition Deta	20. Method of Disposition Deta 20. Location Contract 20. Location Contract 20. Location Contract 20. Location Camelety, cremetory or other place) Camelety, cremetory or other p	



State of Maryland / Department of Health and Mental Hygiene 9

						Cei	tificate	e of	Death			Reg. No.		
	Db. :		1. Decedent'a Name (First, Middle, La	ist)							2. Dete of De		Year	3. Tima of Death
	Physici /Medi		Cosette Ailene M	ARKELL								15, 19		9:10 a.m
	Examir		4a. Facility Name (If not institution, give	re <i>street</i> end nu	ım <i>ber)</i>				4b. City, To	wn, or Lo	cation of Deat		y of Death	7 7 20 6 11
1			Williamsport Nurs	sing Ho	me					W111	Liamspo	rt	Washi	ngton
	Funeral		Social Security Number 6. S		7. Aga (In yrs. la	**	If Undar Months	1 Yaar Deys		24 Hrs. Min.	8. Date of Bir (Month, De	th V Veer)	9. Birthr	placa (Stete or Foreign
	Director		219-12-2496	I□M 2⊠F	73	Yrs.	TOTAL TO	50,0	110010			18,1925		nnsylvania
	pur .		Usual Residence of Decedent 10e. State 10b. County		10c City	Town or Lo	cation							Od Incide City to Incide
	sho	Į.	C-E-STA		100. Oity,									10d. Insida City Limits 12 Yas 2 No
	28a-1	Director	Maryland Wash:	ington		над	erstor					10- Ohioo of	145 - 4 O - 1	100
	with a	ត់	923 Mt. Aetna Roa	a đ			TUI. ZIP	Code	217	7.4.0		10g. Citizan of	USA	ntry/
	eath	era	11. Marital Status		edent Evar in U.S.	12.1	Nes Deced	ont of			noify Van or N	14 Da		can Indian,
	iter d	Funeral	1 Navar Marriad 2 Married	Armed Fo	orces?	10.1	Yes, spec	ify Cul	ban, Maxican	, Puarto	ecify Yes or No Rican, atc.)	Bla	ick, Whita,	
21215-0020	d within 72 hours after death with the Maryland jiens. I than "naturel", or items 23s or 28s-f show tre Medical Examiner must be notified at	þ	31☑ Widowed 4 □ Divorced	If Yes, Gr Yaar or D	ve		I□ Yes 2	No No	Specify:			Specia	ý: Ţ	white
9	2 hou	Completed	15. Decedent's E	ducetion		16a. Deced	lent's Usua	i Occu	pation			16b. Kind of E	Jusiness/In	dustry
215	C	pie	(Specify only highest gra Elementery/Secondary (0-12)	da completed) College ((Giva life. l	kind of wor DO NOT us	k done e retire	during most ed)	t of worki	hg			ľ
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pu	be filed tal Hygid d other	Be	17. Fathar's Nama (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Meiden Sumei	ne)	
Va A		10	J. Atlee Young						E	Edith	ı A. Po	tter		
Maryland	s 1 end 2 should be fi f Haalth and Mental F tam 27 is marked of other traumatic eve		19a. Informent's Name/Relationship (_					er, City or Town		*
	5 # C #		Cassandra Wagama	n – dau					nial D	r.,	Hagers	town, M	d. 21	.742
ore	of Hae of Ham f Itam r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from	0.00	ce of Dispo netery, cran	sition <i>(Na</i> m ne <i>tory</i> or of	ne of ther ple	ece)	ì	Date	20c. Location	- City or To	own, State
altimore,	Pag ment ant: I		4 □ Donation 5 □ Other (Specif		Gr	een H	i11 C	eme	tery	3-	-19-99	Waynes	boro,	Pa.
alt	permit. Pages i Department of H Important: If its any injury or ot once.		21. Signature of Funeral Sarvice Licer	nsee v		1 22	. Nama and	d Addr	ress of Fecilit	y M]	INNICH	FUNERAL	HOME	
m	907 5 9		Cott/11	Men	much	C 41	5 E. 1	Wil	son B1	vd.,	Hager	stown,	Md. 2	1740
	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on e	caused the death.	Do not ent	er the mode	e of dy	ing, such as	cerdiac o	or respiratory a	rrest,		Approximata Interval Between
a	Physiclan													Onset and Death
1	/Medical Examiner		Immediate Cause (Finel disease or condition	De	hydrati Due to (or a	en								10 Days
п	LAUITINICI	_	resulting in death)		Due to (or a	as a conseq	uence of):							
	be disi	Examiner		b. Dy	15 Dhagi	a				_				MONTHS
	and and	хап	Sequentially list conditions, if any, leading to immediate	^	Due to (dr a	is a conseq	uence of):			0 1				
60	be e		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initieted events	c. Am	yotroph		Cate	345	4	SU	erosi	5		
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical	resulting in death) Last		Due to for a	s e conseq	uence of):						1	
36	certi nding use a	2		d										
. Bo	that the death led by the atter detached for u	ician	Part II. Other algnificant conditions of	ontributing to d	eath but not recult	ing in the u	adorbina or	2000	iven In Part I		23h Did	tobecco use or	antributa t	o the cause of death?
Ö	the y th	Physi		onthouting to d	oath oat not rosalt	ing in the di	idenying ce	ousa y	eveninii enti.	٠		Yes 2 No		bably 4 Unknown
٦,	es tha igned be dat	by P										100 2/2/10	0_110	James 4 Distriction
Records,	v requires that been signed b should be date										24e. Was	an autopsy		ere autopsy findings vailable prior to
S		piet									pen	ormed?	CO	empletion of ceuse death?
	e - 5	Completed									1□	Yes 2 No		☐Yes 2☐ No
Vital		Be C	25. Was cese raferred to medical						26 Place	of Death	(Check only			
_ <	Physician: this cartific ral director,	0	exeminer? 1 Yes 2 XNo	Hospital:	Inpatiant 2 E	NOutpatien	t 3 DO	A O	ther .			dence 6 🗆 Oti	ner (Specit	(v)
J Of	g Ph er th	T:u	27. Menner of Death	28a. Date	of Injury 2 th, Dey Year)	8b. Time of		Bc. Inju		-		how injury occu		
Siol	Attending ir death. octor: After by tha fune	atic	1 Natural 5 ☐ Pending investigation	n	,,	ii ijui y	М		Yes 2□	No				
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of tnjury - At homing, etc. (Specify)	e, farm, str	et, factory,	, office		:	28f. Location (City or To	Street end Num wn, State)	ber or Run	al Route Number,
	Ital or urs after ral Dir lled in													
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only 2 Medical Exam	yalclan: To the	best of my knowle	edge, death	occurred a	at the t	ime, date and	d place, a	and due to the	cause(s) and m	anner as s	stated.
	the I	Med	one	and man	ner stated.									
	To To		29b. Signature and titla of certifier	4	_		290.		isa number			29d. Data sign	od (Month,	Dey, Yeer)
		ļ	CHOW	E. W	4		T)3	5/00			Morch	16	1444
		ļ	30. Name and eddress of person who	completed ceus	se of deeth (Item 2	3a) (Type,	Print)		1015	- 1	Pau.	- P.DO	40	^
	-01	• •	31. Date filed (Month, Day, Year)	32 0	> Y C C	JUCK	COUL	k	TRIVE		BUUN	>1>060	· /VV	U
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State of Maryland / Department of Health and Mental Hygiene

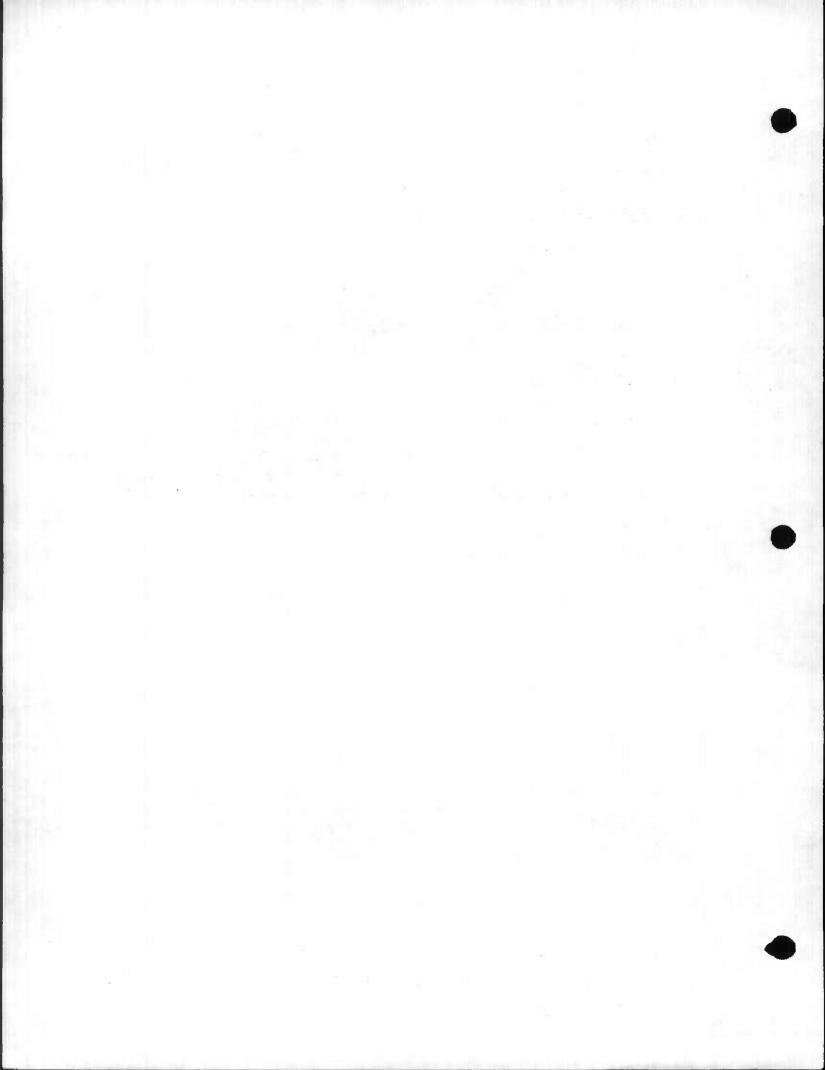
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						Certific	cate of	Death	R	eg. No.	0. 0	2.11
П	Physic	ian	1. Decedent's Name (First, Middle,			~ ^ ~	-		2. Date of Deat Month	h Day	Year	3. Time of Death
ı	/Medi		HOWAR	W A	M	CAC	19		MAR	17 1	999	6.30 PM
7	Exami		4a. Facility Name (If not institution,	give street and number	er)			4b. City, Town, or Lo	cation of Death	4c. County	of Death	
			Western Man	ryland Ho	spital	Cent	er	Hagersto	wn,	Wash	ingt	con
	Funeral Director		5. Social Security Number 214-09-9562 Usual Residence of Decadent	6. Sex 7. /	Age (In yrs. last bir		Inder 1 Yea onths Days	r if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 21	Year) ,1915	9. Birthple Count	lace (State or Foreign try) 1D
	and		10a. State 10b. County		10c. City, Tow	n or Location	n				10	Od. Inside City Limits
	Mary f she	ō	MD Washi	ngton	Hager	stow	n,					1 ☐ Yes 2 ᡚ No
	the 288	9	10e. Street and Number			10	f. Zip Code		1	0g. Citizen of W	/hat Count	- 11
	3a or	ō	12441 Gateway	v Ave.				740	,	U.S.		.,,
20	within 72 hours efter death with the Maryland ilene. Then "natural", or Nems 23s or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decader Armed Forces od 1 Yes 2	s? LNo X			Hispanic Origin? (Spe ban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race Blac	a - America k, White, e	etc.
21215-0020	hour		15. Decedent's	Year or Dates		Decedentis	Haval Oss					
5	C 5 49	Completed	(Specify only highest	grade completed)	104.	(Give kind o	of work done OT use retir	ipation e during most of workii ed)	ng	16b. Kind of Bu		
7	filed within Hygiene. ther than "	mo	Elementary/Secondary (0-12)	College (1-4o				lorker		Aircra	ILC M	1Ig
	be filed htal Hygi d other event, I		17. Father's Neme (First, Middle, L.	ast)				18. Mother's Name	(First, Middle, M	Maiden Sumam	e)	
Maryland	id be ental kad c	o Be	Howard R. Moa	ats				Edith	Bloye	r		
37	d 2 should be filed within the end Mental Hygiene. 7 ie markad other than traumatic event, the M	-	19a. Informant's Name/Relationshi	ip (Type, Print)	19b	. Mailing Add	dress (Stree	et end Number or Rura	/ Route Number	City or Town.	State. Zip i	Code)
	nd 2 ilth er lith er treu		Margaret Moat					way Ave.				
Baltimore,	s 1 and 2 of Health e Item 27 le other tra		20a. Method ot Disposition		20b. Piece of cameter					20c. Location -		
9	permit. Peges i Department of F Important: if ite any injury or ot once.		tx Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe					March 2	0.1999	Hager	stor	an MD
	ortar Inju		21. Signature of Fyneral Service Li		Tour			ress of Facility	0,1333	nager	DCOW	VII FID
ä	Depemil Import any ir		11-11	7()/		Don	-14 E	derin mb.	mpson	Funera	1 Hc	ome, Inc
	_	-	23a. Part. Enter the diamete, or c shock, or head dailure. List of	omolications that cause	ad the death. Do	P.O	.Box	310 Clea	r Spri	ng,MD	2172	22
	Di		shock, or hear failure. List of	nly one ceuse on each	line.	TOT BUILDS THE	mode of dy	ing, such as cardiac o	r respiratory arri	981,	10	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Ceuse (Final	0 -	- ^ -							Onder and Dodge
	Examiner		disease or condition resulting in death)	a. RE	SPIRAT	TOPL	1 FI	ALLURE				
		ē			Due to (or as a	consequence	b ot):		4			
	nsit	Examiner		b MU	171-1V	UFAR	PCT	DEMENT	74			
_^	svacu a end	Xal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	consequence						
68760,	cete be executed physicien and s the burief-trensit		Cause (Disease or Injury thet initiated events	c	RAIN S			ROKE				
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ROX	centi ding			d								
ă	eath ce ettendir for use	ciar	D. H. Ott. J. In. J. In.									
j.	ch th	Physician/	Part II. Other significant condition	s contributing to death	but not resulting in	the underly	ing cause g	iven in Part I.				the cause of deeth
<u>,</u>	that hed by deta								1 🗆 Y	No No	3 ☐ Prob	ably 4 Unknow
ds,	8 6	d by							24a. Was a	n autoney	24b. Wer	re autopsy tindings
000	71 0	Completed							perform		avai	ilable prior to npletion of cause
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or Vital Record	: The li cete he								1 □ Y€	s 2 2 No	1 🗆	Yes 2010
5	Physicien: The this certificate ral director, pag	Be	25. Wes case reterred to medical examiner?	Hospital:				28. Plece of Death	(Check only on	e)		
ō	this raidi	. To	1 ☐ Yes 2 ☐ No 27. Manner of Deeth	1 Inpa			_ DOD	ther: 4 Nursing Hon)
	After After funer	Certification:	1 Natural 5 ☐ Pending			rime ot njury	28c. Inju		8d. Describe ho	w injury occurre	3G	
DIVISION	teat for: the	Cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	nt be		М		Yes 2□No	201 1 (2)			
\geq	P P P	TT.	4 ☐ Homicide determin	ed 286. Place of I	njury - At home, fa etc. <i>(Specify)</i>	rm, street, ta	ictory, office	2	8t. Location (St. City or Town	reet end ryumbe i, Stete)	r or Hurel	Houte Number,
_	pital Surs Filled		200 Codilios 4500-454-	Dharles Total								
	Phospital 24 hours Funeral letely filled	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the bes	of examinetion en	, death occu d/or Investiga	rred at the t ation, in my	ime, date and place, a opinion, death occurre	nd due to the ca d et the time, da	iuse(s) end mai ate and plece, e	ner as sta nd due to	ited. the cause(s)
	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	Mec	29b. Signature and title of cartifier	and manner s	ordieu.			se number		9d. Date signed		
	F 3 F 8	D41112								> li-	110	20
3			,	~ war	707		74	1116	(17/1	119	77
			30. Name end address of person wi		Harris State of State					(
			Ian Newbold	1500 Pe	nnsylva	nia A	Ave.	Hagersto	wn, MD.	21742	-	
	Sta Registr		31. Date tiled (Month, Day, Year)	32. Hegis	strar's Signature		Spark					
	negisti	वा	MAR 191	1000 /		- · /	up coep	2				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

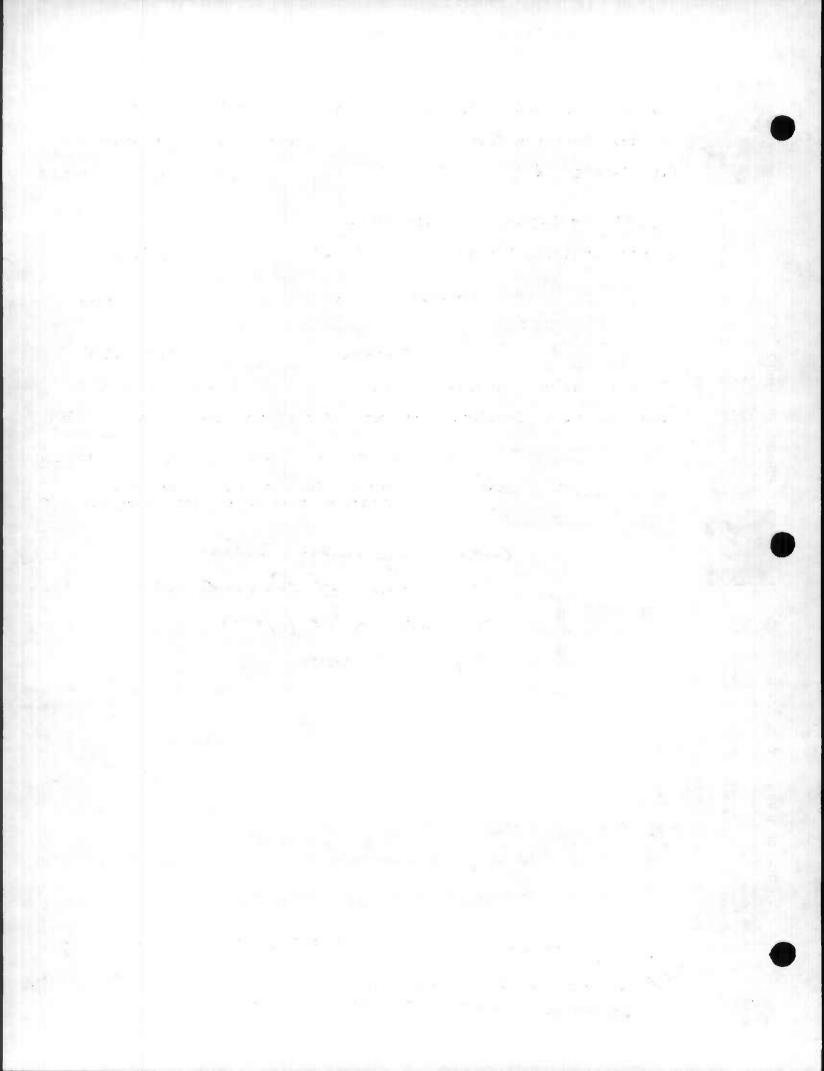
	Certificate of Death		Reg. No.	1 1 1	126
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of D	eath Day	Year	Tima of Death
/Medical	Zowell browder mondair	march	91 1	999	10:39
Examiner	At the bar and an area of the area of the same of the	r Location of Dea			
	Washington County Hospital Hagers		Was	shingto	n
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		rth ay, Yeer)	9. Birthplace	(Stete or Foreign
Director	215-20-8671 75 Yrs.	Jan.	7, 1924	Maryla	
2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			104.1	nside City Limits
Department of Heelth and Mentel hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, the Medical Examiner must be notified at once. To Be Completed by Funeral Director					Yes 2 No
Pot de	Maryland Washington Hagerstown				2.00 20.00
D Pe	10e. Street and Number 10f. Zip Code		10g. Citizen of V		
e 23	229 Division Avenue 21740	(Casaita Van and)	USA	e - Amarican In	dian
r flome 23a or 28a-f a riber must be notified Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Nevar Married 2 ☑ Married 1 □ Yes 2 ☑ No	erto Rican, etc.)	Blac	ck, White, etc.	iolari,
by B			Specify	whi	te
a b	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B	usiness/Industr	v
r, tra Medical	(Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired)	orking			
The Co	Elementary/Secondary (0-12) College (1-4or 5+) 12 O owner/operator		tax s	service	
ant, e		ame (First, Middle	, Maiden Sumen	10)	
To Be	Rev. William F. Murray Bessi	e L. Mil	ler .		
	19s. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or	Rural Route Numi	ber, City or Town,	Stete, Zip Cod	(e)
5	Kathleen E. Murray - wife 229 Division Ave., H	lagerstow	m, Md.	21740	
ŧ	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town,	State
7 04	1 149 Dunal 2 I ICremation 3 I Hemoval from State	3-24-99	Hagers	town, Ma	arvland
In a	21. Signature of Funeral Service Licensee 22. Name and Address of Facility N	1			
any Ir	SCANDING A 415 E. Wilson Blv				740
	- Cold IIII I ameed				proximate
- voleien	23a. Part1. Enter the disease or complications thet coused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	as or reopriatory		Inte	rval Between set and Death
nysician Medical	Immediate Ceuse (Final			5	
xaminer	Immediate Ceuse (Final diseasa or condition resulting in death) s. Diffuse Abdominal Sanc	oma		1 2	months
ē L	Due to (or as a consequence of):			1	
physician end is the burial-transit edical Examiner	Sequentially list conditions. Due to (or as a consequence of):				
ial-tr	Sequantially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury			!	
A but	Cause (Disease or injury that initiated events to death) set that initiated events are within a death) set.				
es the	resulting in death) Last				
i for use	d				
d for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23h Dic	I tobacco usa co	ntribute to the	cause of death?
igned by the attending be detached for use e by Physician/M	Section of the state of the section of the state of the s		Yes 2 No	3 Probably	
een signed by the attending physician end thould be deteched for use as the burial-transit eted by Physician/Medical Examir			200	2_1100mm	,
os u			s an autopsy		utopsy findings
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ate has pege 2		• •	Yes 2 No		s 2 No
O Page			/*	1 1 7 8	9 ZU 140
rect B	examiner? 1 Yes 2 No	Home 5 Dec		ne /0000/4 1	
5 7	1 Inpatient 21 EH/Outpatient 3 IDOA 4 Invising	Home 5 ☐ Res	how injury occur		
Director: After In by the funer ertification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No		,,		
al Director: After t led in by the funera Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location	(Street end Numb	per or Rurel Ro	ute Number.
d in b	4 Homicide determined building, etc. (Specify)	City or To	wn, Stete)		
	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and pla	ce, and due to the	cause(s) and ma	anner as steter	
To the Funeral Dir completely filled in Medical Ceri	(Check only one) Check only curred at the time	, date and placa,	and due to the	cause(s)	
To the comple	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month), Day.	Year)
. 0	X \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2	2/1	12/01	10%
	30 Name and address of person who completed course of death (flow 201) The Point	2	2/0	~ 1	
	30. Nsmå and address of person who completed cause of death (Item 23a) (Type, Print) Div. Hamdan 363 S. Cleve Land Ave.	La 100	1 01	M117)
CATA	31. Date filed (Month, Dey, Year) 1000 32 Property Stonature	ray. Pr	10 01	1-11	
State	MAR 2 4 1999				

DHMH 16 Rev 6/95

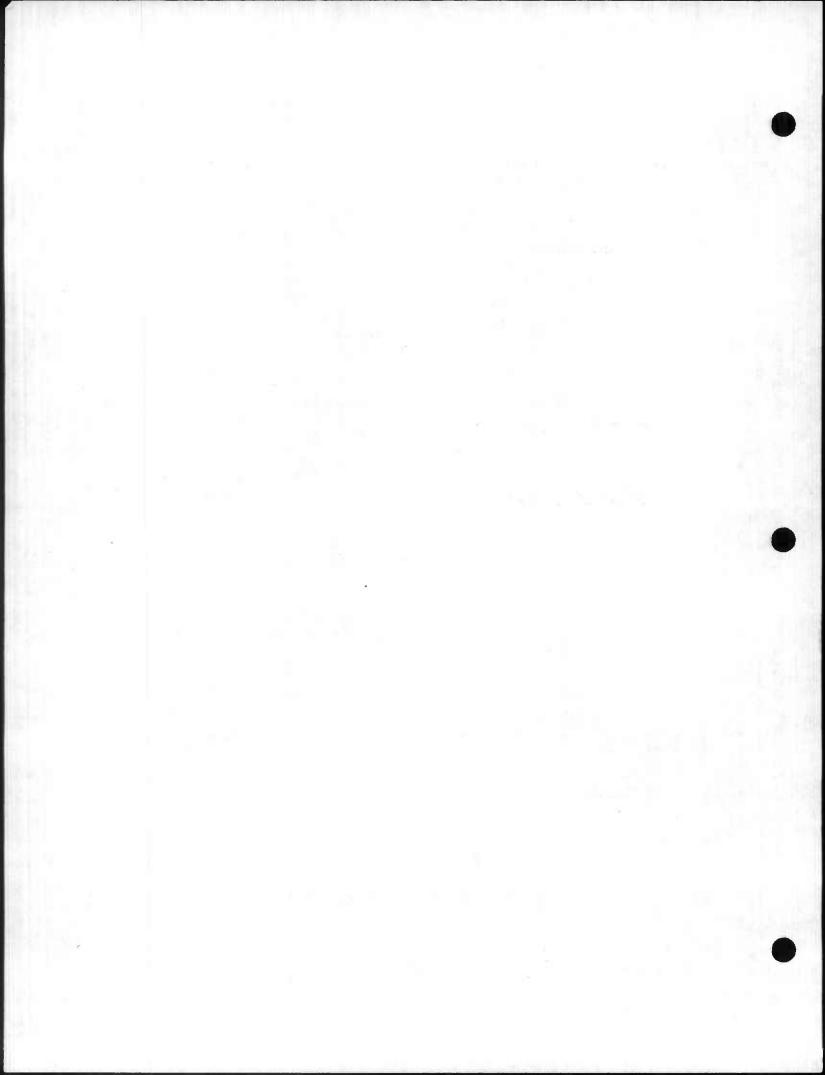


State of Maryland / Department of Health and Mental Hygiene 9 9 1 7 2 7

					Certificate of	Death		Reg. No.		F 19 10 a 1
		1. Decedent's Name (First, Middle, L	ast)				2. Dete of De			3. Time of Death
Physicia	_	HORACE CLI	FFORD B	RENNER	MC CLEL	LAND	March	21, 19	99	6:30 P.N
/Medica	_	4a Facility Name (If not institution, g		HEINITEH	HO OLLL	4b. City, Town, or	Location of Death	4c. County	of Death	
LAdilling	٠,	50 East Anti	etam Stre	et		Hagers	town	Was	hing	ton
Funeral				(In yrs. last birti	hday) if Under 1 Year	r If Under 24 Hrs.	8. Date of Bir		9. Birthpla	ce (State or Foreign
Director		216-14-6451	1⊠M 2□F	77	rs. Months Days	Hours Min.	Novembe	r 23,19	21 Ma	aryland
end **		10a. State 10b. County		10c. City, Town	or Location				100	d. fnside City Limits
Sa-f sho	Director		ngton	Hag	erstown					¹X☐ Yes 2☐ No
with the	P	10e. Street end Number 50 East Antie	tam Stree	t	10f. Zip Code 2174	0		10g. Citizen of V		y?
Jeath 2	Jera	11. Merital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Ongin? (S	pecify Yes or No	- 14. Rac	e - Americer	
020 urs s	by Funeral	1 Never Merried 2 Married 3 Widowed 4 Divorced) 942–1945	1 ☐ Yes 2 ☐ No		o Rican, etc.)	Specify	ck, White, et Whit	
21215-0020 d within 72 hours af jiene. r than "natural", or the Wed call Exern	Completed	15. Decedent's (Specify only highest g	rade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of wor ed)	rking	16b. Kind of Bu	usiness/Indu	stry
vithin iene.	E	Elementary/Secondary (0-12)	College (1-4or 5		Carpenter			Constru	iction	
4 6 9 7		17. Father's Neme (First, Middle, Las	st)		our porroor	18. Mother's Nar	ne (First, Middle,			
d be antal	To Be	Norman Ral	oh McCl	elland	Sr.	Helen	Leona	a Bre	enner	
Aar 2 sho 1s mand	۲	19a. Informant's Name/Relationship Virginia M.	(Type, Print)	19b.	Mailing Address (Street) Bast Anti	et and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip C	
CHNL	-	20a. Method of Disposition			Disposition (Name of		Date	20c. Location -		
Pages nent of mrt: If h		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemeter	aven Cemetory or other pl					Maryland
Baltimo permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service Lice.	Brady		22. Name end Add Andrew K. 40 East Ar	Coffman F				04740
K 6876(artificate be ing physicle e es the bur	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c. Mo	Due to (or as a control of the total of the	rasis +	ony Fa	; lare spate ver	arith.		Yesu
BO)			0						i	
P.O. that the de detached detached	Physician	Part II. Other significant conditions	contributing to death bu	it not resulting In	the underlying cause g	given in Part I.		tobacco use co Yes 2□ No	ntributa to t	the cause of death?
as the	P								~	
Records, P	Completed							an autopsy ormed?	evai	re autopsy findings liable prior to apletion of ceuse eath?
C 9 5 6	EO						10	Yes 2000	10	Yes 20 No
Vital sician: The certificata irector, par	0	25. Was cese referred to medical				26. Plece of De	ath (Check only	one)		
	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospitef:	nt 2 ER/Out	patient 3 DOA	ther.	lome 5 Resi		er (Specify))
이 등 등 등		27. Menner of Deeth 11 Natural 5 Pending 2 Accident Investigati	28a. Date of Injur (Month, Da)	y. 28b. T	ime of 28c. Injury W		1 1	how injury occur		1 3.0
Division or Attending efter death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not determine		iry - At home, fai :. (Specify)	m, street, factory, office	9	28f. Location (City or To	Street and Numb wn, Stete)	ber or Rural	Route Number,
	edicai Ce		thysician: To the best of aminer: On the basis of and manner sta	exemination end						
ithin of the smple	Me	29b. Signature and title of orbitier	and manner sta		29c. Licer	nse number		29d. Date signe	d (Month, D	Pay, Year)
F 3 F 8		DOA lar			D	3549	7		2-	99
Çît, la ta		30. Name and eddress of person wh	completed ceuse of de	eath (Item 23a) (Type, Print)	4 11		1	111	100
		J.A. PASHA	MD 3	761	1,115	T, Ha	gers	Least	nu)	121740
Stat Registra		31. Date filed (Month, Day, Year) MAR 2 3 19	32. Aggistre	er's Signature	. spark	a C				



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** Betty Jane Marshall 1999 1903 march /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County oi Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Data of Birth Hours Min. De C. 30, Year 27 If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Months 1 ☐ M 2 🖸 F Maryland 218-24-1886 71 Director Usual Rasidanca of Dacedant the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be nothled at Director No Yas 2 No Maryland Washington Funkstown 10e Street and Number 10f Zip Code 10g Citizen of What Country? 8 43 Frederick Road 21734 United States 238 Funeral deeth 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. items : 12. Was Dacedant Evar In U.S. Armed Forcas? Peges 1 and 2 should be filed within 72 hours after of the short of Health and Mental Hygiena.
mt: if item 27 is marked other than "natural", or item iny or other traumate event, in a market in its in the state. 1 Nevar Married 2 Married 1 ☐ Yas 21 No 1 Yas 2 No Specify: White Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry O^{Collega (1-4or 5+)} Elementary/Secondary (0-12) Homemaker Her own 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Harry Mills Mildred Hamburg 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Walter Marshall 43 Frederick Road, Funkstown, Md 21734 Husband 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Pege Department of Important: If any Injury or once. Cedar Lawn Memorial Park 3-15-99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md 21740 L. Victal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abook, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examine Premans 1-2 days physician and s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated avents rasulting in death) Last Dua to (or as a consequance oi): Box 68760 Physician/Medicai Dua to (or as a consequance of) Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t Pulmonery 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Charic obilinchia Š Accidence Suym Annah 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raiarred to medicel axaminar? Be 26. Placa oi Death (Check only ona) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No this 28a. Data ol Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Medicai Certification: 28b. Tima of 28c. Injury at Work? Division or Attending 1 DNatural 5 Panding invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, streat, factory, office building, atc. (Specify) 4 Homicida 29a. Certifier 1 🖰 Curtifying Phyeician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) D18019 march 12, 1999 12200 MO 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Hagerstown Maryland 334 Datta Street 32. Registrar's Signatura 31. Data iiled (Month, Day, Year) State MAR 1 6 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** norch 9:00 Ruth Viola MUNSON /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dev. Year) **Funeral** Months Deys Hours 1□M 20 F Director 160-16-2574 Aug. 29 1918 Pennsylvania 80 Usual Residence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Director 288-1 Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b "natural", or flams 23a 11011 Coffman Avenue 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black White atc Illed within 72 hours after 1 Nevar Married 2 Married 1 Yas 2 No If Yas, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Department Store 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maiden Surnama) Be Pages 1 and 2 should be nant of Health and Mental into it liem 27 is marked or marked o To Samuel E. Shields Daisy Ellen Bivens 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Important: If Item 27 any injury or other tr Sue Munson - Daughter 11011 Coffman Avenue Hagerstown, Maryland 21740 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, cremetery or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 3/15/99 | Hagerstown, Maryland 21. Signature of Funeral Sarvice Licenses 22 Nama and Addrass of Facility Minnich Funeral Home 15 E. Wilson Blvd. Hagerstown, Maryland 21740 Unnie 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physiclan** /Medical Immediate Causa (Finel 1 w/c disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): the for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of death? 2 No 1 ☐ Yas 2 ☐ No 1 Yas Division of Vital 25. Wes case refarred to medicat axaminar? or Attending Physician: 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To Impatient 3 DOA 2 ER/Outpatient this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of After 5 Pending invastigation Natural 2 Accident n 24 hours after death.

e Funeral Director: After pietely filled in by the fun 1 Yas 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. 29e. Certifier edicai compietely (Check only one) within 2 the th 29b. Signature end, titla of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May cause of death (Item 23a) (Type, Print)

State

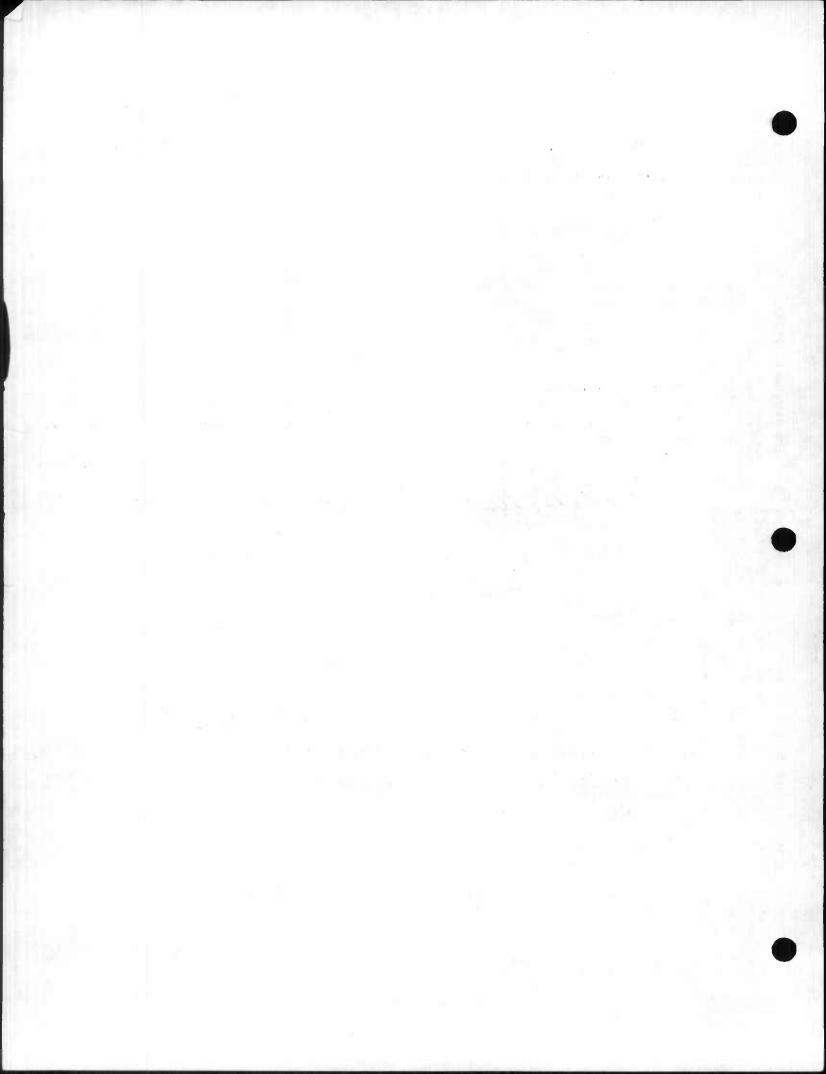
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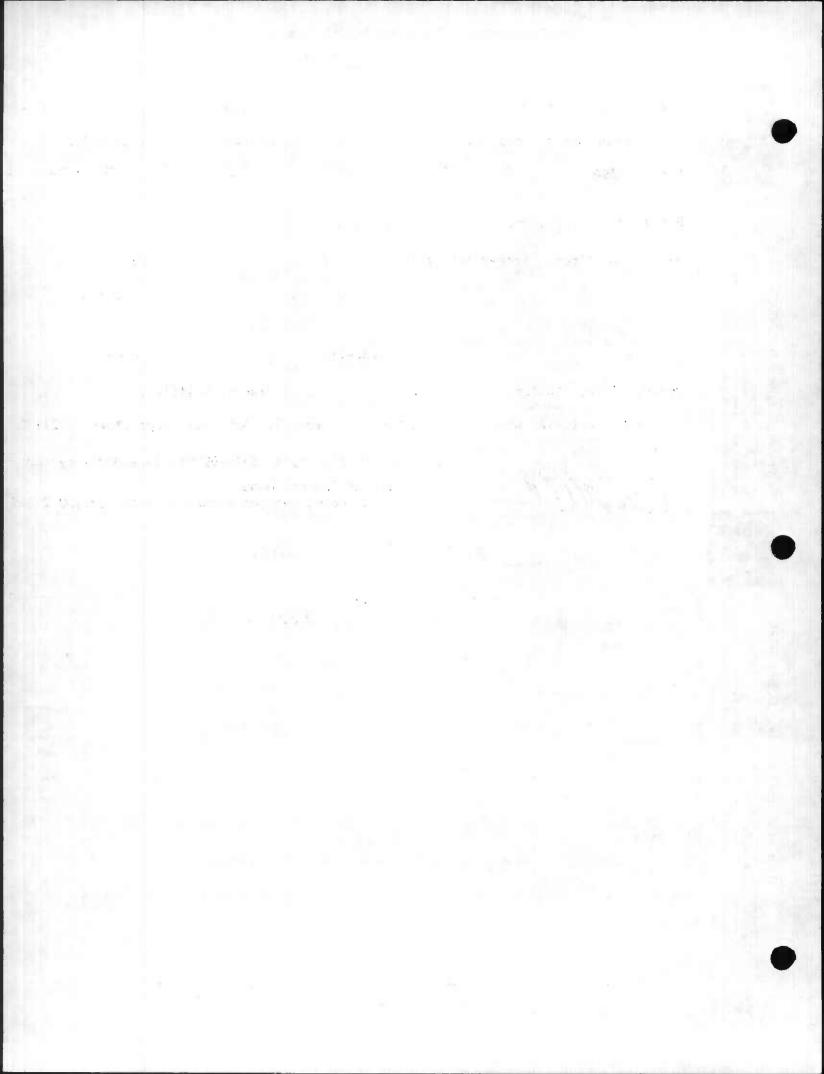
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32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 99 10730

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Physician /Medical	F	Ruth Irene N	lello	††							March	11	1999	2:55
Examiner	4a I	Facility Nama (If not institut	tion, giva s	traat and i	nu <i>mber)</i>			4	4b. City, Tow	m, or L	cation of Death	4c. Cou	nty of Death	
	V	Washington Co	ounty	Hosp	ital				Hage	rst	own		Washi	naton
uneral		ocial Sacurity Number	6. Sax		7. Aga (in y	s, last birthday		lar 1 Yaar	If Undar 2	4 Hrs.	8 Date of Birt	h (Yang)	9. Birth	place (Stata or Fore
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ury		4 □ Donation 5 □ Other	(Specify)		Gr	eenlaw	n Men	noria	l Park	3	-15-99	Willia	mspor	t, Marylan
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			Decedent's Nema (First, Middle, Last)				2. Date of Deet		3. Tima of Death
	Physici /Medi		Mary Alice Musick				March	10 1999	8:35 am
	Examir	ner	4a. Facility Nama (If not Institution, giva street and number)				Location of Deeth	4c. County of Dea	
_			Williamsport Retirement Village 5. Social Security Number 6. Sex 7. Aga (In yrs. Jas	et hirthday)	If Under 1 Yaar	Witliam		Washi	
1	Funeral Director		209-07-5757 Usual Residence of Decedent	Yrs.	Months Deys			902 Pen	rthplece (Stete or Foreign country) nsy I van i a
	yland			Town or Loc	cation				10d. inside City Limits
	Mar al	tor	Maryland Washington	Will	iamsport	r			1 X Yes 2 □ No
	or 28	Directo	10e. Street end Number		10f. Zip Code		10	og. Citizen of What C	ountry?
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	ar de	Funeral	11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces?	13. W	Vas Decedent of Yes, specify Cul	Hispanic Origin? (ban, Mexican, Pue	Specify Yas or No- to Rican, atc.)	14. Race - Am Bieck, Whi	
20	be filed within 72 hours after death with the Maryland tal Hyglena. d other than "natural", or items 23a or 28a-f ahow avant, the Medical Exeminer must be notified at	by F		1	□Yas 2 No	Specify:		Specify:	White
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מ	88118		I Can Colom					liamsport	,MD 21795
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700,	be exe clan a ourial-	cal Ex	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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	The late his page	Com					1 □ Ye	s 2 10 No	1 ☐ Yes 2 ☐ No
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5	shyst this c	2	1 Tyes No Hospitel: 1 inpatient 2 EF		3LI DOA			nce 6 Other (Spi	ecify)
5	ding h. After funar	tion	1 Neturel 5 Pending (Month, Day Year)	8b. Time of Injury	28c. Inju Wo	uryat ork?]Yes 2 □ No	28d. Describe ho	w injury occurred	
JINISIOII	Atten r deal actor: by the	ifica	3 Suicide 6 Could not be 28e. Plece of Injury - At home	e, ferm, stre	-		28f. Location (Str	reet and Number or F	Rural Route Number,
5	afta or afta afta or a	Certification:	4 Homicide determined building, etc. (Specify)				City or Town	, Stete)	
	To the Hospital or Attending Physician: The law within 24 hours aftar death, within 24 hours aftar death. To the Funeral Director: Aftar this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Madical Examiner: On the best of examinetion end menner steted.	odge, deeth n and/or invi	occurred et the t estigetion, in my	lme, dete end plec opinion, death occ	a, end due to the ca urred et the time, de	use(s) end manner a te end place, and du	s stated. e to the cause(s)
1	Withi To the	M	29b. Signature and title of certifiar			se number		d. Dete signed (Mon	
			JEHOWE. MD		D3:	3700	/	MARCH 10,	1999
			30. Name and eddrass of person who completed cause of deeth (Item 23	_	Print)		7 .		21717
	Sta	721	31. Data filed (Month, Day, Year) 32. Registrar's Signatur		erlook	-br. 1	boonsk	oro, MC) 21115
	Registr	1004	MAR 1 1 1999	19	15,000	the start			1999

Please	State o		d / Depa		of He	ealth a		lental Hy	giene g	ible.	10732		
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4a Facility Nama (If not institution, gir	va street and nur	m <i>ber</i>)			4t	c. City, Tov	wn, or Lo	narch ocation of Death					
WASHINGTON COUNT						HAC	יפסקי	TOLINI	W	ACHTI	NGTON		
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10a. Stata 10b. County		10c. Cit	ty, Town or Lo	cation							10d. fnsida City Limits		
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7				MIX	XER				Y COMPANY				
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WILLY PLUME						IDA	FLO	RENCE P	RICE				
19a. Informant's Name/Ralationship	(Type, Print)		19b. Mailir	ng Addrass (Straat a	nd Numbe	er or Rur	ral Routa Numbe	er, City or Town	, Stata, Z	ip Code)		
TINA M. REEDER/GE	RANDDAUG	HTER	7929-	A17 OI	LD N	OITA	NAL	PIKE, B	OONSBOF	20, M	D 21713		
20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 [4 ☐ Donation 5 ☐ Othar (Speci		Stata	Place of Dispo cematary, crer NOR CEI		ar place)	3	Data /20/98	20c. Location		Town, Stata MARYLAND		
21. Signature of Funaral Service Lo 23a. Part 1. Enter the disease, or con shock, or heart failure. List only	an Par	ıl M. D	ean BA	Name and ST FUN	Addrass VERA	L HOM	y Œ	7606 01 Boonsbo	d Natio	nal 1	Pike		
Immediata Causa (Final disaase or condition resulting in death)	a. P	NEUM								1	50AYS.		
Sequentially list conditions,	b. R	ght-co	or as a consac Webso V or as a consac	ascul	-AR	AC	CID	ENT			24 hors.		
if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last	c (A	trail Dua to (c	Jibn or as a consag	Mat	IDN	•					2 Monito		
Part II. Other significant conditions	contributing to de	aath but not ras	sulting in tha u	ndarlying cau	usa giva	n in Part I.		23b. Did	tobacco use c	ontributa	to the cause of death?		
						1 Yes 2 No 3 Probably 4 Nnknown							
	-1-6								an autopsy rmed?	8	Were eutopsy tindings available prior to complation of causa of daath?		
								10	Yas 2 No		1□Yas 2 ÓNo		
25. Was cesa reterred to medicel axeminar?	Here's T				0		of Daa	th (Check only o	one)				
1 ☐ Yas 200 No			ER/Outpatier		1	4 LI NU	irsing He	oma 5 Rasi			oify)		
27. Mannar of Death 1 Netural 5 Panding 2 Accident invastigation	on	of Injury th, Day Year)	28b. Tima o Injury	f 28	c. Injury Work 1 🔲 Y	et ? /as 2 🗆	No	28d. Dascribe	how injury occu	urred			
3 Suicida 6 Could not determined	280. Flace	of Injury - At h		raat, factory,	office			28f. Location (ber or Ru	ural Routa Number,		

To the Hospital or Attending Physician: The lew requiras that the deeth certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettanding physician and completely filled in by the funeral director, paga 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical **Examiner**

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend Department of Haalth and Mental Hygiene. Involve an article as the Marylen Important: If them 27 is marked orther than "natural", or freme 23a or 28a-f show say injury or other traumatic event, the Medical Examinet must be notified as once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Willyam Plume

29a. Cartifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and mannar es stelad.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

D28365

3.16.99

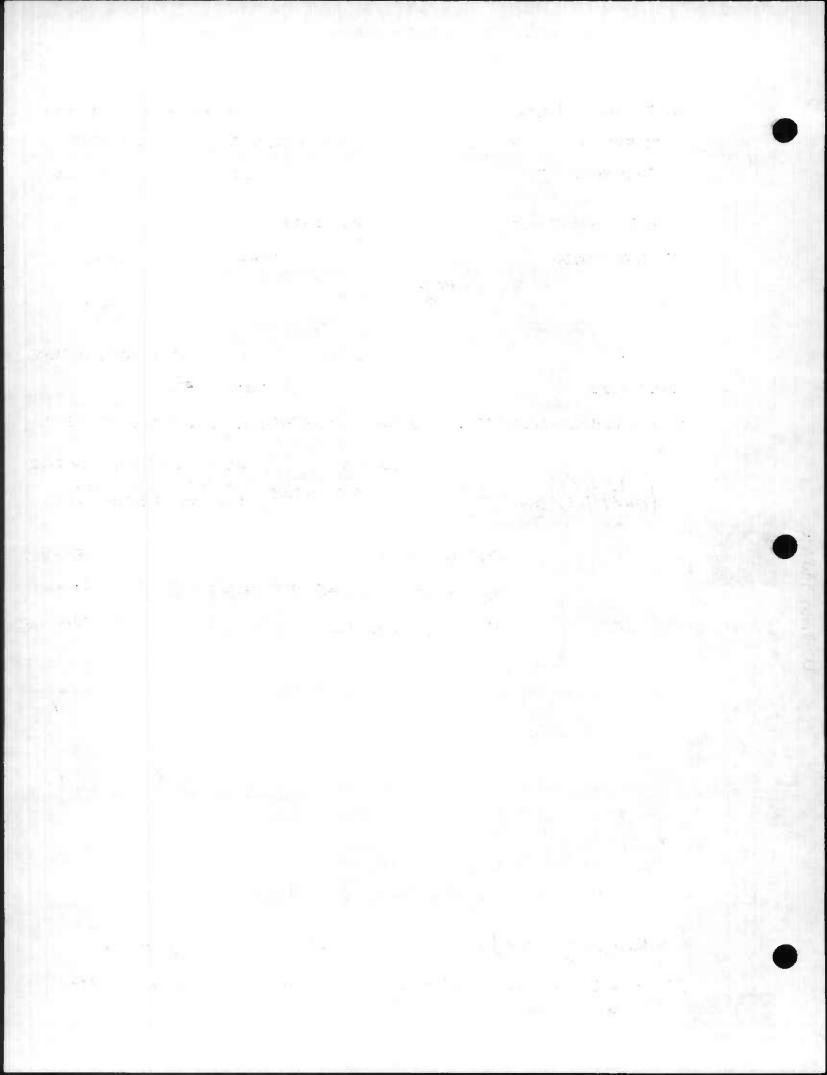
30. Nama and address ot person who completed callse ot death (Itam 23a) (Type, Print)

32. Registrar's Signatura

G. Annul 21790. API AR

State Registrar

31. Data filed (Month, Day, Yaar) MAR 1 9



State of Maryland / Department of Health and Mental Hygiene C Certificate of Death 2. Data of Death March 1. Decedant's Nama (First, Middle, Last) Month 3 TERSON 10:00pm 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St.
If Undar 24 Hrs. 8. Date of Birth
Hours Min. 8. Date of Birth
(Month, Day, Year) Marys If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 □ F Months Days Yrs. 88 April 28,10 North Carolina 10h County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2□No Maryland Prince Georges Eagle Harbor, Aquasco 10g. Citizan of What Country? 16901 Eagle Harbor Rd U.S.A.

14. Raca · Amarican Indien,
Black, White, atc. 20608 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 □ Never Married 2 □ Married if Yas, Giva Yaar or Datas:1 9 4 3 - 1 9 4 5 1 ☐ Yas 2 ☐ No Specify: Specify: Black 3√ Widowad 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Planning College (1-4or 5+) Skilled Labor Maryland Park and 17. Fathar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Maiden Surname) Halbert Patterson Annamenta Patterson 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20772 Christine Johnson- Niece 16611 Candy Hill Road Upper Marlboro, Maryland 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata MD Veterans Cemetery March 30,1999 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensea 22. Nama and Addrass of Facility Adams Funeral Home Aquasco, Maryland 20608 or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. JANGRENE LEFT OCARD Dua to (or es a consaquanca of): HEMATOM 23b. Did tobecco use contribute to the cause of death?

Physician /Medical Examiner

usa as the burial-trar

signed by t

this cartificate

al or Attending Physics after death.

I Director: After this ed in by the funeral d

To the Hospital o within 24 hours af To the Funeral D' complately filled i

Physician/Medicai

þ

Completed

Be

2

Certification:

Medical

The law requires that the death cartificate be axecuted

P.O. Box 68760.

Records,

Division of Vital Attending Physician:

Department of Important: If eny injury or once.

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

6

"natural",

al Hygiene.

. Pages 1 and 2 should be fill ment of Haalth and Mental Hant: If item 27 is marked oth lury or other traumatic even

traumatic event, the Medical Examiner

Director

Funeral

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Completed

tha Maryland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

ALVIN

5. Social Security Number

10a Stata

11. Maritei Status

578-42-6850

Eiamantary/Secondary (0-12)

20a. Mathod of Disposition

23a. Part1. Entar tha disa us

immediate Ceusa (Final

diseesa or condition resulting in deeth)

Usual Rasidance of Decedent

Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaasa or Injury that initiated events rasuiting in daath) Last

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown

24a. Was an autopsy performed? 1 Yas

24b. Wara autopsy findings eveilable prior to complation of causa of daath?

PERTENSION

26. Place of Death (Check only one)

1 ☐ Yas 2 No

25. Wes case refarred to medical axaminar? 1 Yas 22 No

5 Panding Invastigation

1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year)

28b. Time of

Othar: Wursing Homa 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

5 ☐ Rasidence 6 ☐ Othar (Specify) 28d. Dascribe how Injury occurred

6 Could not ba 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Cartifiar

27. Mannar of Deeth 12 Natural

2 Accidant

3 Sulcida

4 Homicide

Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

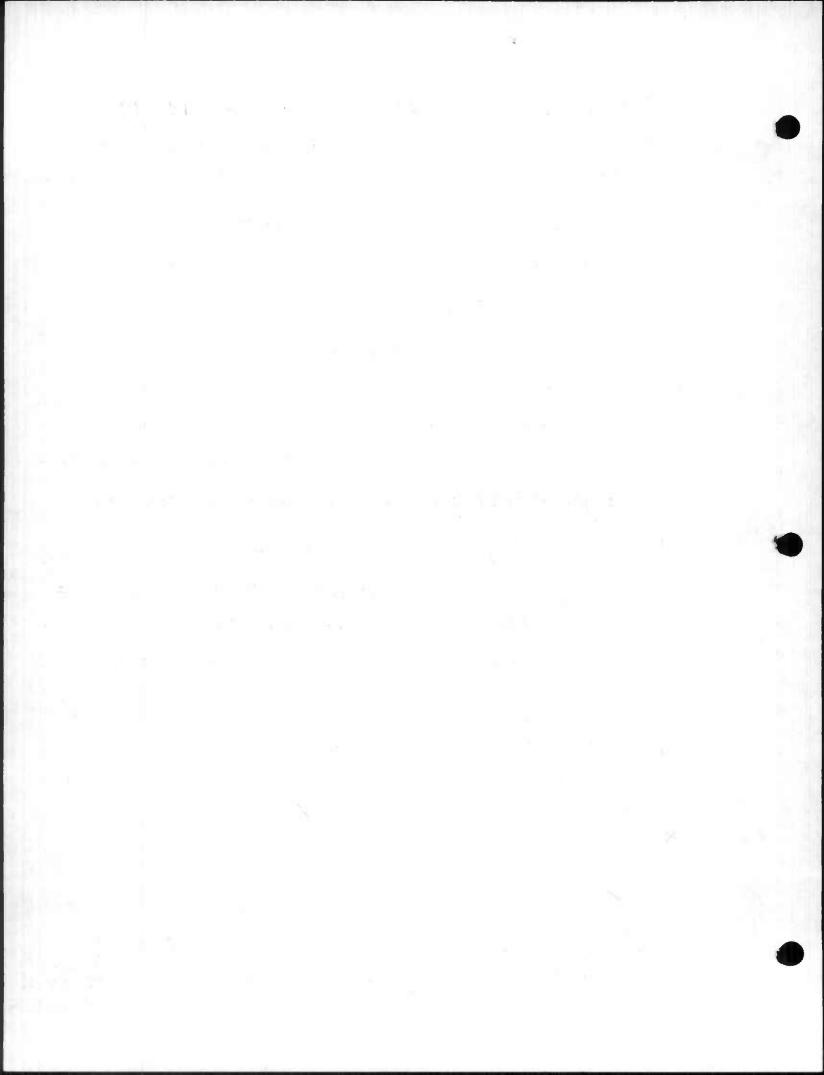
30. Neme and address of person who/completed causa of deeth (item 23a) (Type, Print) ARCIC

Road Suite 204

State Registrar

31. Data filed (Month, Day, Year)

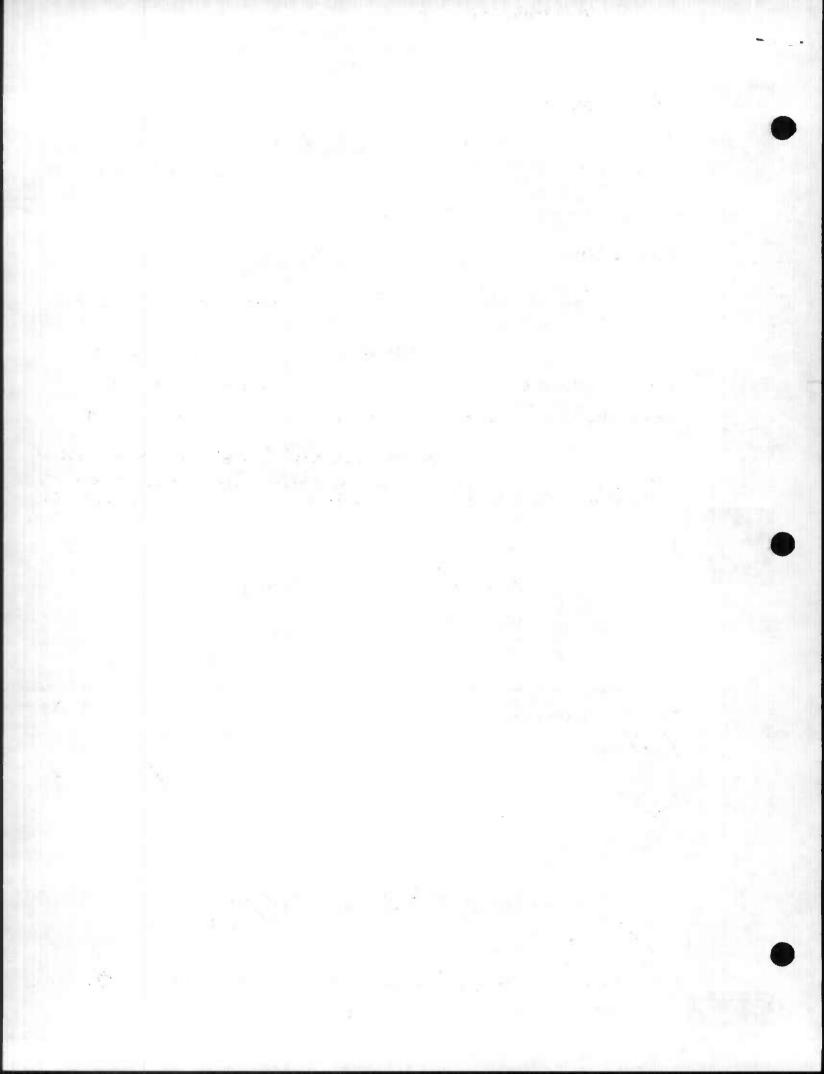
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

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- 1	1.1	- /	1	1.2
- 1	2.7	- 6	1. 1	Do D

					Cen	tificate of	Death		eg. No.				
Physician	1. Decedent's Name (First, Middle, Last) ysician JOSE ROSARIO						2. Date of De Month		Day	Year	Time of Deeth		
/Medical	2036	7 100						03	13 99		1934		
Examiner	11						,.	t, or Location of Death 4c. County of Death					
		University of Maryland Medical System 5 Social Security Number 6 Sex 7 Age (In us lest biothday) If Under 1 Yo						Baltimore T If Under 24 Hrs. 8. Date of Birth 9. Birthpolace (State of					
Funeral Director	580 =50 −0455 1 Mm 2□ F 61 Yrs. Months						s Hours Min.						
be filed within 72 hours effer deeth with the Maryland tall Hygiane. d other than Instural; or items 23e or 28e-f show event, the Madical Examiner must be incitited. Be Completed by Funeral Director	10a. State							10d. Inside City Limits					
a-f.s	Maryland	Washingt	con	На	gerstow	n					Yes 2□No		
or 28	10e. Street and Nu	mber				10f. Zip Code		1	0g. Citizen of V	Whet Country?			
th will	110 East Avenue					217	40		USA				
offer deeth with the Mark terms 23s or 28s-1 so in the mark terms to retire.	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U s?	,S. 13. W	as Decedent of Yes, specify Cu	Hispanic Orlgin? (S ban, Mexican, Puer	pecify Yes or No- o Rican, etc.)		e - American Ir ck, White, etc.	ndian,		
or h	1 Never Mar	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2			No ty⊈Yes 2□No				Specify:				
ural', o	3 ☐ Widowed	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					Puer	to Rican		Hispa			
be filed within 72 hours of tiel Hygiener than "natural; or event, m Madical Evan Be Completed by F	(Spe	 Decedent's Ed cify only highest gra 			(Give k	ent's Usual Occi and of work don	e during most of wo.	rking	16b. Kind of B	usiness/Industr	У		
hen hen m	Elementery/Sec	Elementery/Secondery (0-12) College (1-4or 5+)				O NOT use retir	(60)						
filed with Hygiene ther the int, me	17 Father's Name	(First, Middle, Last)			labor	rer	18 Mother's Na	me (First, Middle, I	COnstr				
Mental be farked or atic eve	Juan	Rosa						stina		iguez			
semil. Pages 1 end 2 should be file be presented to Health and Mental Hy mportant: If Item 27 is marked other any injury or other traumatic event 200s. To Be C	•				10h Mailine	Addrona /Ctro	et and Number or Ri			0	da l		
d 2 s h an h an traur	Vivian	Rosario	Wij	fe			nue Hager				<i>1</i> 0)		
Healt Healt ther	20a. Method of Dis		****	20h E	Place of Dienos	ition (Name of	T		20c. Location -		State		
Pages nent of nut: If Ne nry or o	1 🗆 Burlal 2	Cremation 3		te	ROSE TEM	atory or other p	EMETERY TORY						
t. Pag ntment tant: If		5 ☐ Other (Specify		Ha				3/1 8 /99 H	agersto	own, Ma	ryland		
permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryler Department of Health and Mentel Hygiene. Introcreant: if them 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be incliffed once. To Be Completed by Funeral Director	21. Signature of F	uneral Service Licen	1000	0	Ger	ald N.	ress of Facility Minnich	305 N.	Potomac	Stree	t		
40240	flax	00.01	mmo	-11		eral Ho		Hagerst		-			
	23a. Part1. Enter shock, or he	the disease, or com art failure. List only	plications that caus one cause on each	sed the deat n line.	h. Do not ente	r the mode of d	ying, such as cardia	c or respiratory arr	est,	Inte	proximate erval Between set and Death		
Physician	Immediate Course /Finel									On			
/Medical Examiner	Immediate Cause (Final disease or condition a. Ex SANGULUO TON resulting in death)										2		
10-11-11-11-11				Due to (d	or as a consequ		^						
sit sit			b. Acute	Aort	ic Di	SECTION .	Ascendin	9		į			
end Fran	Sequentially list of	onditions,		,	or as a consequ	ence of):							
ificete be executed g physician end es the buriel-transit	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease o that Initiated even	erlying r Injury	c. Hy, 200 to	-w 3,0 d									
flicate be ex physician ss the burief	that Initiated even resulting In death)	s Last		Due to (o	r as a consequ	ence of):				i			
			d							<u> </u>			
eath cert ettendin I for use													
het the de det by the deteched	Part II. Other significant conditions contributing to death but not resulting in the underlying cause						given in Part I.	23b. Did tobacco use contribute to the cause					
ed by detect	Chrowic Re	Chronic Renal Insufficiency						1 🗆 Y	ee 2 No	3 Probabi	y 4 Unknow		
The law requires that the death certificate has been signed by the ettending page 2 should be deteched for use es Completed by Physician/Me	1 11	A //						24e. Was a	in autonsv	24b. Were a	autopsy findings		
requestion should	Asthu	Asthua						performed? available prior to completion of cau of death?			ole prior to etion of cause		
2 00 Q											th?		
Co pag								1 U Y	es 2 No	1 □ Ye	s 2 No		
hysician: his certificant director	25. Wes case refe examiner?	rred to medical	Hoonital:			10		ath (Check only or	ne)				
			Hospital: Inpe		ER/Outpetient 28b. Time of	3LI DOA	-	g Home 5 Residence 6 Other (Specify)					
	1 Natural					28c. In	ork? □Yes 2□No	28d. Describe how injury occurred					
feath for: / the f	2 Accident 3 Suicide	2 Accident investigation M						28f. Location (Street and Number or Rural Route Number,					
or At offer of or Direct or tiff	4 Homicide 31 Suicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)						City or Town, State)						
pital filled		1 A Canaladan Pa	veloler: To the be-	et of multi-	udodeo dest	conurred at the	time data and story	and due to the	auco(a) a==	anner en state	4		
he Hospi in 24 hou he Funer pletely fil	(Check only one)	2 Medical Exan	ysician: To the bes niner: On the basis and manner	of examina	tion and/or inve	estigation, in my	time, date end plece opinion, death occi	rred at the time, d	ause(s) and mo late end place,	end due to the	ceuse(s)		
2 5 2 5	29b. Signature and	fittle of certified	and manner	ावास्य.		29c. Lice	nse number	2	9d. Date signe	d (Month. Dav	, Year)		
Z matical	1/	127	//						22 /	2/100			
To the Comp		-											
Within Total	Ken	voll &	Low	1				(12/1	2/9/9			
within To the company	30. Name and add	ress of persoon who	completed cause o	f death (Item	n 23a) (Type, F	Print)	1-10	1	11	199	7 13		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** 2:25 A.M March EDWIN GEORGE REUS /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Boonsboro Fahrney-Keedy Home Washington | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pey, Year) | 03/22/1912 5. Sociel Security Number 6. Sex 1 M M 2 ☐ F 9. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 86 Yrs 578-26-9345 Director Massachusetts Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Directo Maryland Washington Boonsboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8507 Mapleville Road 21713 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White p 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. 8 Years College (1-4or 5+) Budget Analyst U.S. Government 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) is marked or Edwin Augustus Reus Viola Pickney Barber 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 end 2 nent of Heelth int: if item 27 is James D. Reus, Son 220 Potomac Street, Boonsboro, Maryland 21713 other 1 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State injury or Smithsburg Crematory 03/12/99 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signeture of Funeral Service Licensee P. 87 7606 Old National Pike 22. Name end Address of Fecility any ir Boonsboro, Maryland 21713 P. Steven Danfelt, Jr. Bast Funeral Home 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel 2 2000 ? reumans diseese or conditio resulting in death) Examiner Due to (or es e consequence of): Examiner end-trans Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): as the burial-to Physician/Medical Due to (or es e consequence of): for use Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? deteched o. signed by t Accident Suizum Dirach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Utiliknown Ceretro varantes þ respotitionalism 24b. Were eutopsy tindings eveileble prior to completion of ceuse of deeth? Hyperterine Completed 24a. Wes en eutopsy performed? page 2 1 Yes 2 €No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Wes cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Matural deeth. 1 Yes 2 No Investigation 2 Accident or Attendent efter deeth Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide 24 hours 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the I within 2 To the I complet 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 12, 1997 - waa mo D18019 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Vasant Datta, M.D. 334 Mill Street, Hagerstown, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

George

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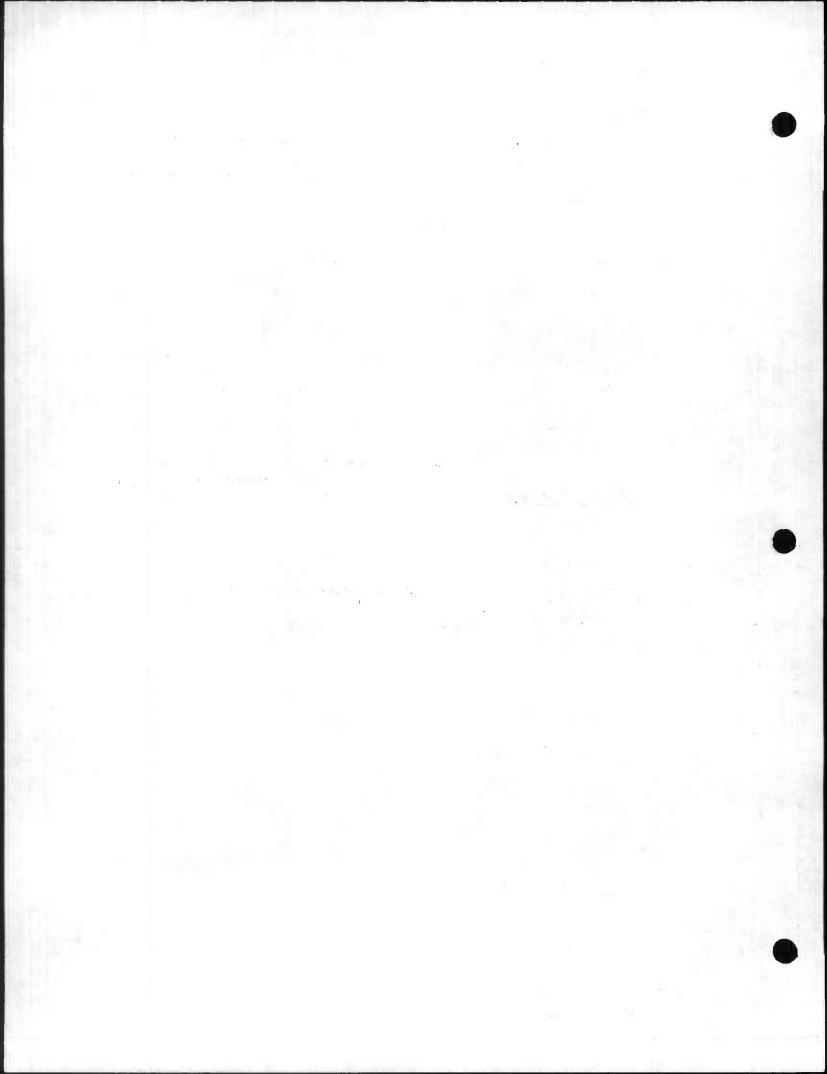
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Physician Morch 318 Virginia June SOCKS /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Months Days Yrs. Director 29 1925 Maryland 220-18-1100 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Wedical Examples must be notified at No Yes 2□ No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 813 Washington Avenue 21740 U.S.A. Funeral daath 12. Was Decedent Ever in U,S.
Armed Forcas?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiana. Important: if Item 27 is marked other than * any fijury or other traumatic event, the Heal and place. Elementery/Secondery (0-12) College (1-4or 5+) 0 11 Laborer Shoe Manufacturer 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Clarence Benjamin Horning Violet May Keckley 19a. Informent's Name/Ratetionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Socks - Husband 813 Washington Avenue Hagerstown, Md. 21740 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/13/99 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Minnich Funeral Home fred Li Vistel 415 E. Wilson Blvd. Hagerstown, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Copparent heart attack nun Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of Hyperlange afterwelecruter Physician/Medical Due to (or as e con Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 28 No 3 Probably 4 Unknown heurt derease þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was en eutopsy performed? Completed 1 Yes 2√No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical exeminar? 26. Placa of Death (Check only one) Hospitel: 1 | Inpatient 2 | SER/OutpatienI 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2√ No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct 4 Homicide edical 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data end place, end dua to tha cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the ceuse(s) and manner stated. 29b. Signeture end little of certifier 29c, License number 29d. Date signed (Month, Day, Year) hus D 12194 Mar 10 Horald R I when 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (hi) 348 HAGICRSTOWN Mill HR TRITCH Villed (Month, Day, Year) 32. Régistrar's Signeture State MAR 1 0 1999 Registrar

Virginie



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Yeer Month **Physician** ARDEMIS ROY 3 99 14 1735 /Medical 4a Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 EDGE CT. BERLIN If Under 24 Hrs. WATERS WORCESTER Birthplece (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number **Funeral** Days Hours Months 79 Yrs 180-16-6834 Usuel Residence of Decedant **Director** 1 - 13 - 20PA permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at another. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 MD. Directo WORCESTER BERLIN 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21811 U.S.A. CT. Funeral 14 WATERS EDGE 12. Wes Decedent Ever in U,S. Armed Forces?

1/54 Yes 2 □ No
If Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNO Specify Specify: by WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast greda completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) PURCHASING AGENT 12 VISHAY TECHNOLOGY 18. Mothar's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be EDWARD SERPOSS HOSANNA TEMOYAN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) GLENN ROY WATERS EDGE CT. BERLIN, MD. 21811 20b. Plece of Disposition (Nema of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Date 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State SALISBURY CREMATORY 4 Donetion 5 Othar (Specify) 3-15 SALISBURY, MD. 21. Signature of Funeral Service Licen 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, because on each line. Approximete Intervel Between Onset end Death **Physician** Gneer /Medical Immadleta Causa (Finel Zyrs disease or condition resulting in deeth) Examiner Dua to (or es e consequance of) Examiner The law requires that the death certificate be axecuted ettending physician end for use es the bunal-transit Sequentielly list conditions, if eny, leeding to immediata ceusa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Dua to (or as e consaquence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequanca of) signed by the el Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? been si 24a. Was en autopsy Completed his certificate hes b 1 Yas No or Attending Physician: Be 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28e. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Panding death. 1 Yes 2 No investigation aftar death.
Director: A 6 Could not be datamined 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Diccompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, and dua to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred et the time, dete end place, end due to the cause(s) 29a Cartifiar Medical 29d. Date signed (Month, Dey, Year) 295. Signature and title of peffil 29c. Licansa number

completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

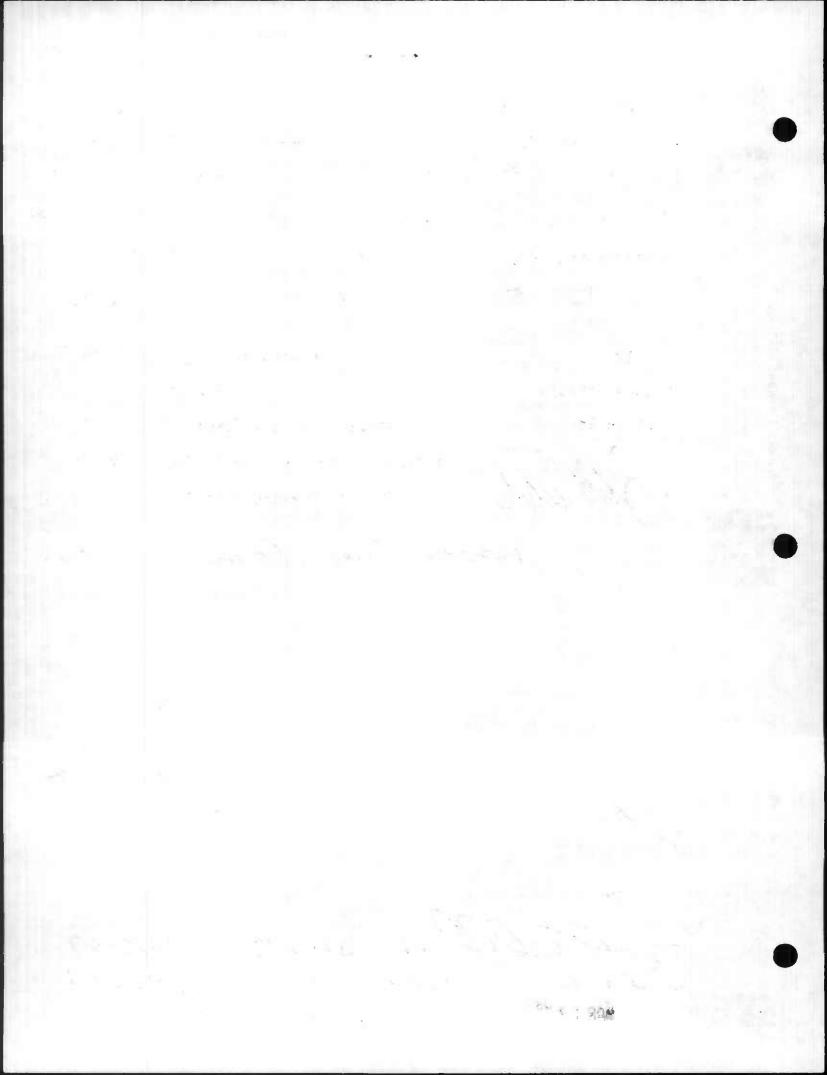
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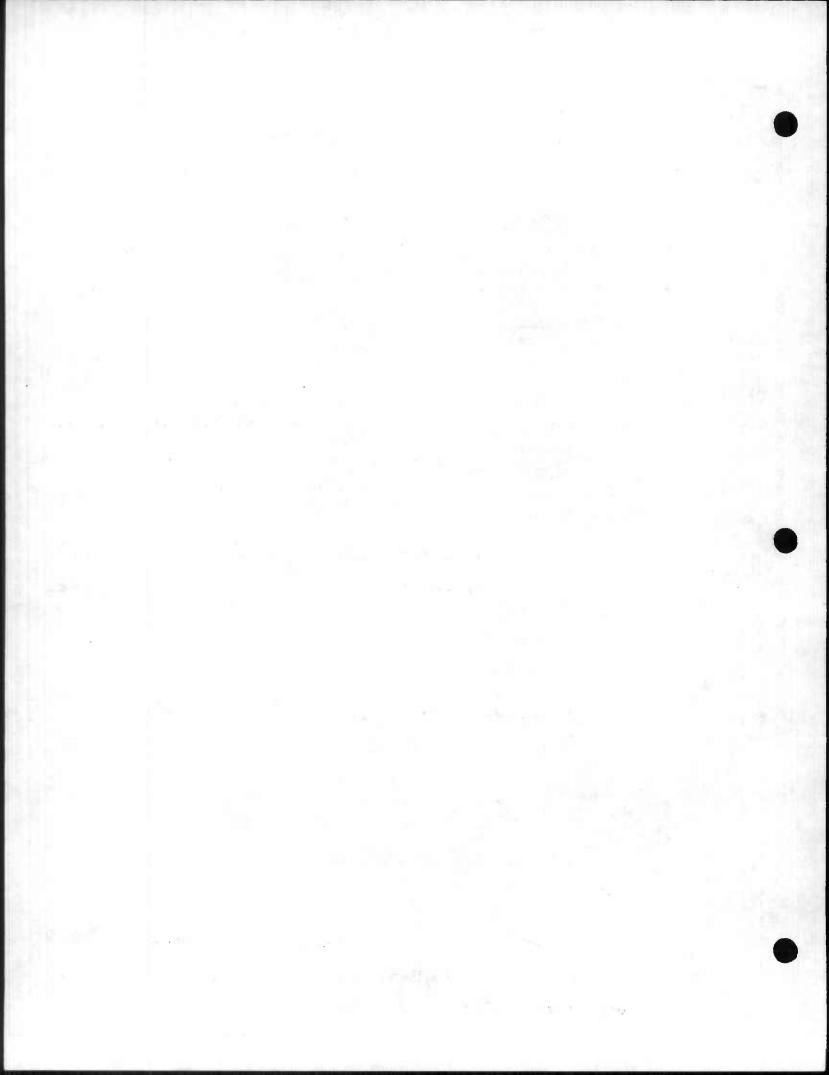
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 03 March 13 2125 SPICER JAMES J. /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours Min. | March 25, 1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 20 F 74 219-32-4805 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show inotified at 1 ☐ Yes 2 No Keedysville Directo Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21756 U.S.A. 3703 Chestnut Grove Road Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 6 Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 hours Department of Heelith and Mental Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic avers. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 Chestnut Grove Road, Keedysville, Md. 21756 Gilbert L. Hunt Baltimore, 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 DBurial 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Other (Specify) 03-17-99 Rose Hill Cemetery Hagerstown, Maryland 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Andrew K. Coffman Funeral Home, Inc. K. hell Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, euch es cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximate Intervet Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) scute Myocardial Marchin /Medical Examiner Examine neumonia attending physician end for use as the burial-transit Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records. P.O. Box 68760. edicai Due to (or as a consequence of): Physician/M Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive jaundice by Parlingon's Disease 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 25 No Hospitet: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funaral tospital or Attending Ph 4 hours after death. "unerel Director: After the ely filled in by the funeral 27. Menger of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28a. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di complately filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29d. Data signed (Month, Day, Year) March 13, 1999. 29c. License number 29b. Signetura and title of certifier 144996 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

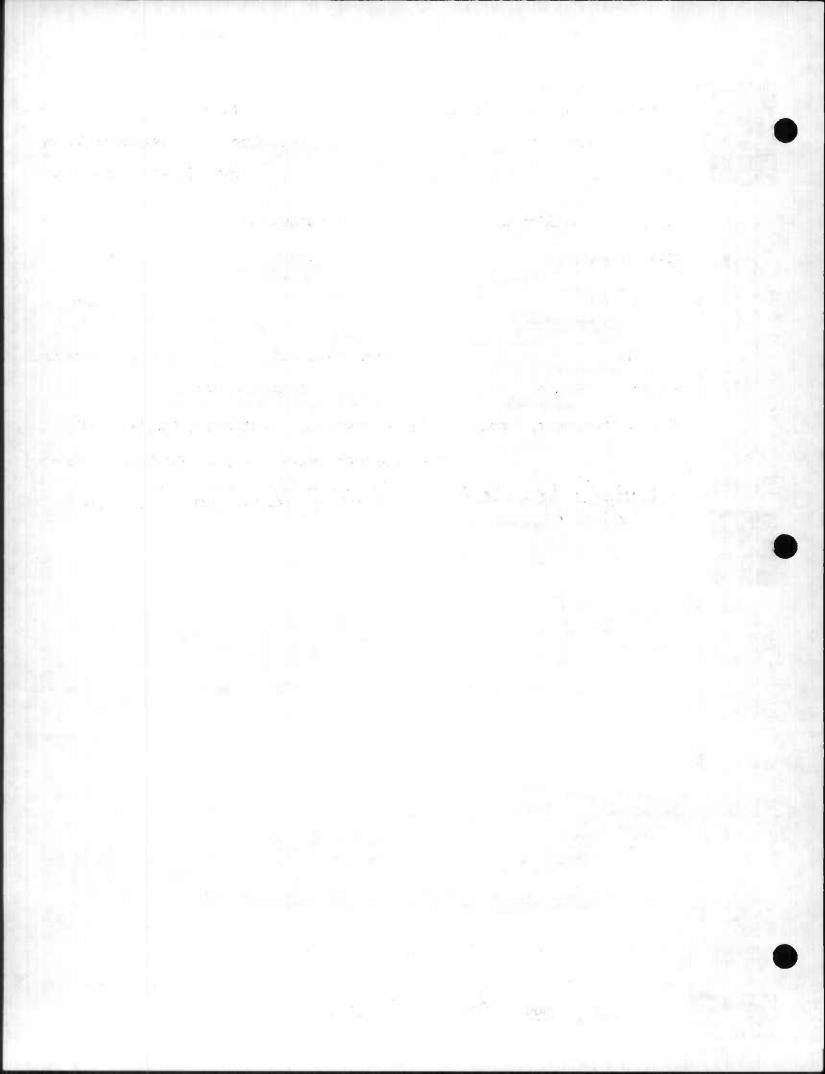
Z. MONK MD >0311 LANDAWS BOONS BORD MD 21713. 32. Redistrar's Signature 31. Dete lited (Month, Day, Year) State MAR 1 6 1999 Registrar



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		30. Name and address of person													
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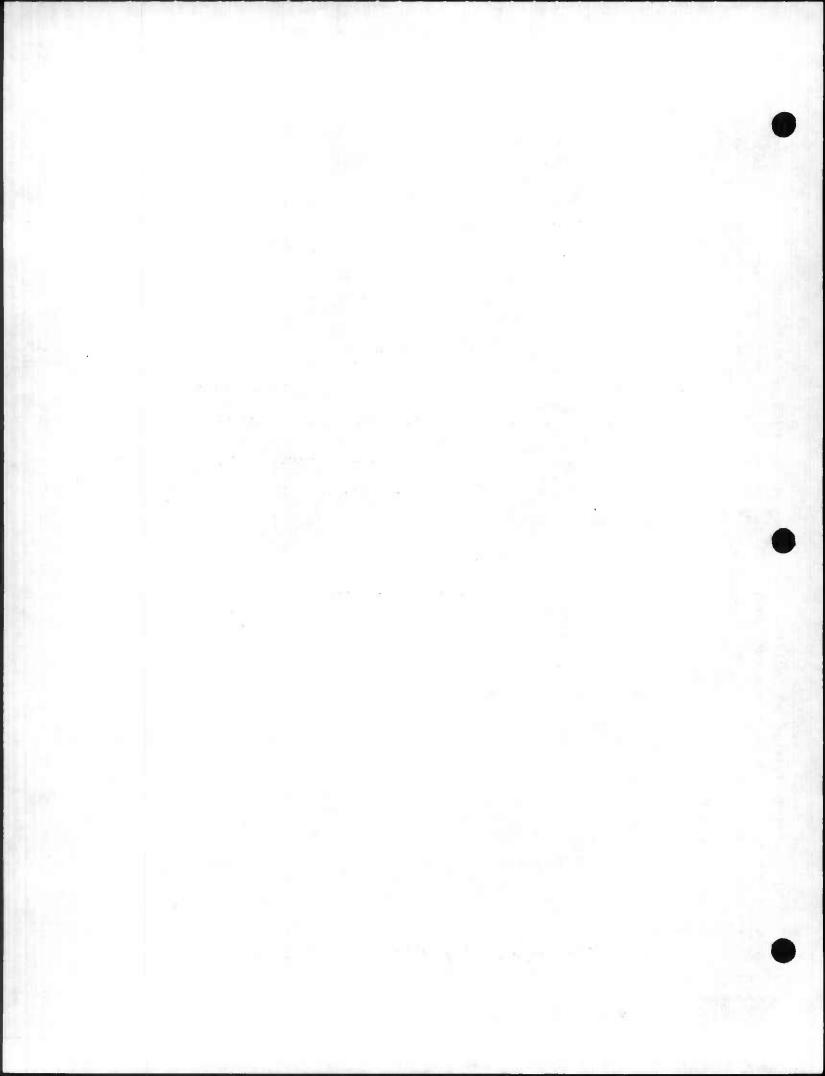
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State of Maryland / Department of Health and Mental Hygiene 9 9 1 7 4

					Cei	tificate of	f Death			Reg. No.		0 4 4 0
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or the	by Fu	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? [No		Was Decedent of f Yes, specify Cu I ☐ Yes 2 ☒ No			city Yes or No Rican, etc.)	Specifi	ce - Americ ck, White, o y: W	
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yalot V	To E	examiner? 1 ☐ Yas 2 ☑ No	Hospitel: 1 (1) Inpat	ient 2 ER/C	Outpatien	1 3 DOA	Other: 4 No	ursing Hon	na 5□Rasi	dence 8 Ott	har (Specif	(y)
VISION OF Attending Physic r death. ector: After this c		27. Menner of Death 1 Naturat 5 Pending 2 Accident invastigation	28a. Date of Inj (Month, Da	ay Year) 28b	Time of Injury	W	juryet /ork? □ Yes 2 □		28d. Describe	how injury occur	rred	
	certification:	3 Suicide 6 Could not l 4 Homicide detarmined	289. Place of In	njury - At home, tc. (Specify)	ferm, str	eet, fectory, offic	10	2	28f. Location (City or To		ber or Rura	al Route Number,
Hospita 24 hours Funeral	edical Cert		hysician: To the best miner: On the basis of and manner s	of examination a								
of the rightin	¥ ×	29b. Signeture and title of curtifier				29c. Lice	nse number			29d. Date signe	ed (Month,	Dey, Year)
- 35	(a)	Mule	Yall	my a	M	D	450	136		3/16/	99	
		30. Name end eddress of person who	completed cause of	death (1) bm 23a	(Type,	Print) (Cam	DUS	Rd.	1	tic m	d	
Reg	State gistrar	31. Dete filed (Month, Day, Year) MAR 1 7 1		trar's Signature	S.	Spar	Kel			7		



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 16, 1999 4c. County of Deeth 12:00 NOON Frank Spinella March /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth **Examiner** Washington County Hospital Washington County 9. Birthplece (State or Foreign Country) 8. Defe of Birth (Month, Day, Year) Jan. 2, 19: 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 15M 20 F Months Deys Hours Min. 106-18-8871 75 Yrs. 1924 Director New York Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23s or 28s-f show social Example: must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18609 Preston Road 21742 USA Funeral 14. Rece - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, efc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Merried 25 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White h 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Itam 27 Ia marked other than "natur any Injury or other traumatic event, the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) School Custodian Public School District 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Michael Spinella (Unknown) Sarah 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 David Luther Court, Cockeysville, MD 21030-1741 J. John Spinella/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Mar. 18 Smithsburg, Maryland Smithsburg Crematory 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 ieuclos A Approximete Intervel Between Onset end Deeth Immediate Cause (Fine) diseese or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lesf Physiclan/Medical Due to (or as e consequence of esn for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed

Physician /Medical Examine

with the Maryland

72 hours after death

altimore, Maryland 21215-0020

physician and the burial-transit the a signed by to page 2 s certificate funeral director, Be Certification: To SH After

The law requires that the death certificate be executed

Attending Physician:

ò Hospital

0

death.

Director:

thin 24 hours after the Funeral Dire impletely filled in b

within 2 To the

Spinella, trank

25. Wes cese referred to medical exeminer?

5 Pending

Investigation

6 Could not be

1 Yes 27 No

27. Manger of Deeth

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

20 No 1 Yes

1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

🕊 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Nedical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b, Signature 29c. License number

28e. Dete of Injury (Month, Day Year)

29d. Date signed (Month, Dey, Year) March 16,

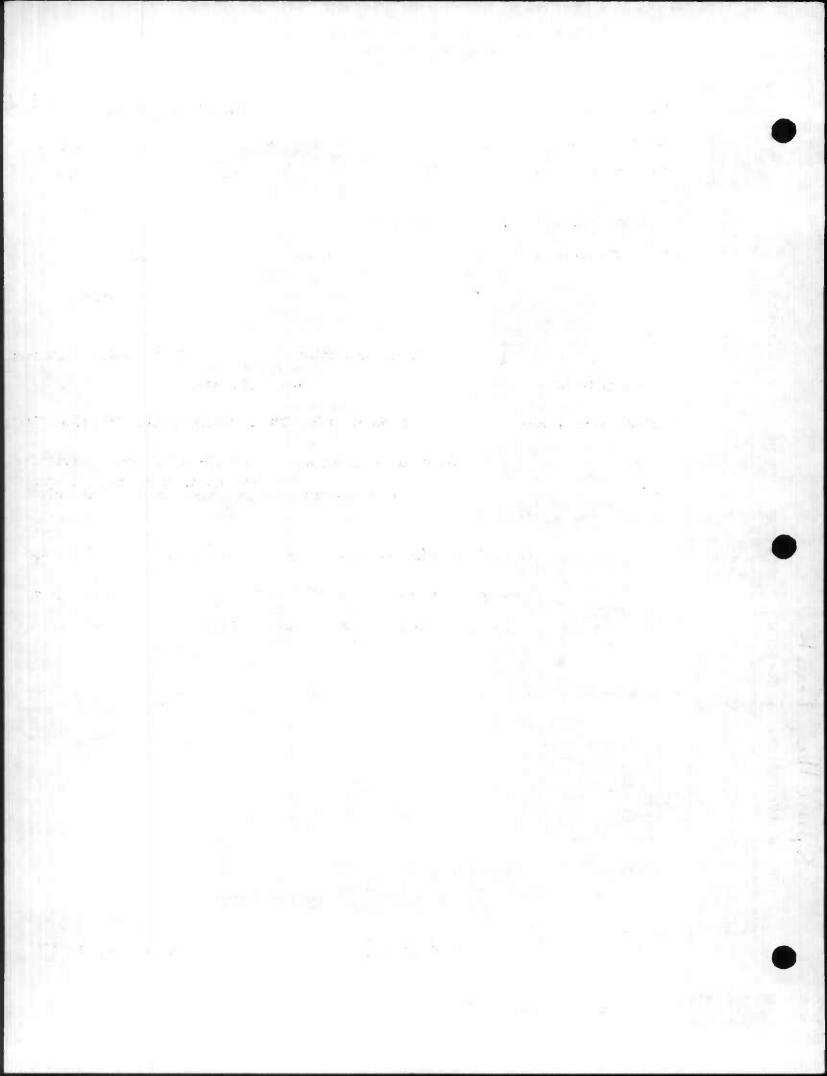
wor and address of person who completed cause of deth (ttem 23e) (Type, Print)

State Registrar

Medical

31. Dete filed (Month, Day, Year) MAR 1 8 1999 32. Registrar's Signature books

28c. Injury et Work?



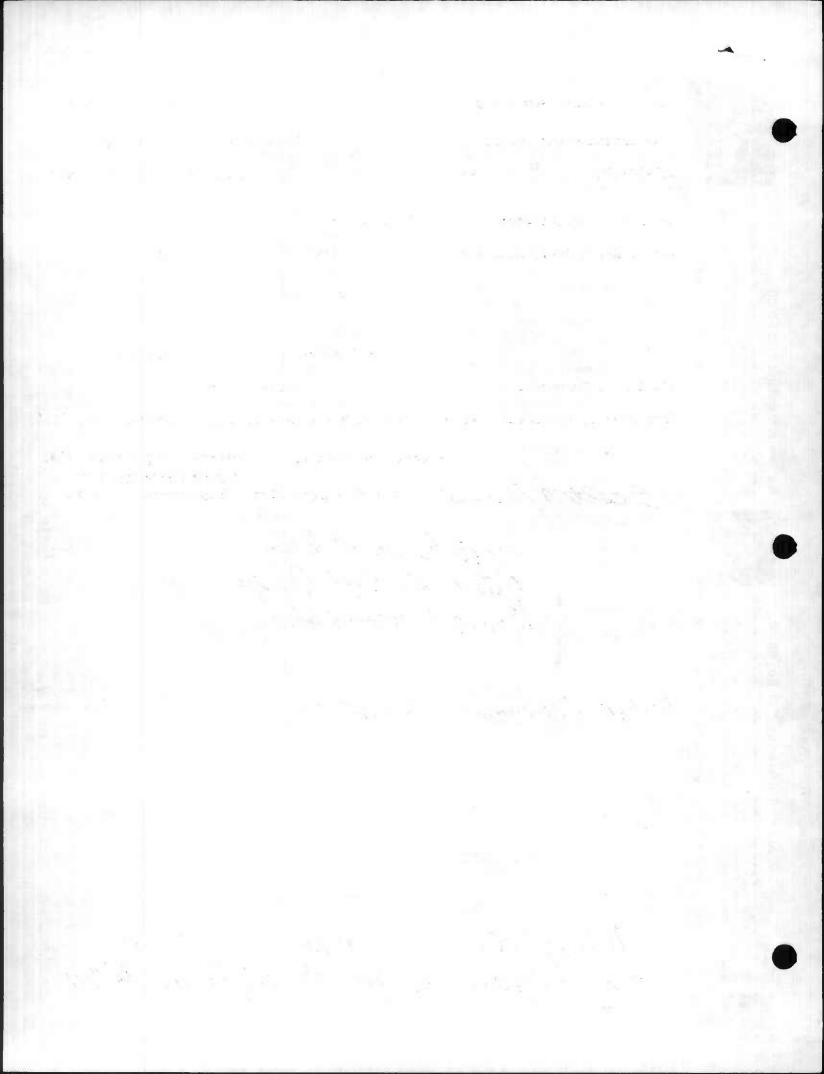
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death March Physician Leonard Edward SHOEMAKER 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Under 1 Yeer Months Devs If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 F Deys 81 217-10-2904 Jan. 17,1918 Director Maryland Usual Residence of Deceden the Maryland 10c City Town or Location 10d Inside City Limits 10e State 10b County 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? WITH 7 is marked other than "natural", or items 23a or trsumatic event, the Medical Examiner must be 145 E. North Ave., Apt. 1 W 21740 USA Pages 1 and 2 should be filed within 72 hours efter death nent of Heelth and Mental Hygiene.

Init: If term 27 Is marked other than 'natural', or theme 23 any or other traumatic event, its Medical Examination mustry or other traumatic event, its Medical Examination mustry. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Narried white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) truck driver 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William H. Shoemaker Nannie Sketon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Geraldine E. Shoemaker - wife 145 E. North Ave., Apt. 1W, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 IXCremetion 3 ☐ Removel from State Department Important: If any Injury or Hagerstown Crematory 3-18-99 Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility MINNICH FUNERAL HOME 2002101 Mund 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner the death certificate be executed physician and s the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Box 68760. Physician/Medical Sa esn 23b. Did tobacco uea contribute to the cause of death? Pert II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. Rope Grelon 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24a. Wes an eutopsy Completed certificate hes b lirector, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical exeminer? 28. Piece of Death (Check only one) Be To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/2 Impatient 211 No 2 ER/Outpetient 3 DOA 1 Yes After this 28e. Date of Injury (Month, Day Year) 27, Menne of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat the Funeral Director filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, end due to the cause(s) end menner steted. 29a. Certifier Medicai To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tale of partifier 29c. License number

death (Item 23a) (Type, Print)

Registrar

Shoemaler, Leonard Edward

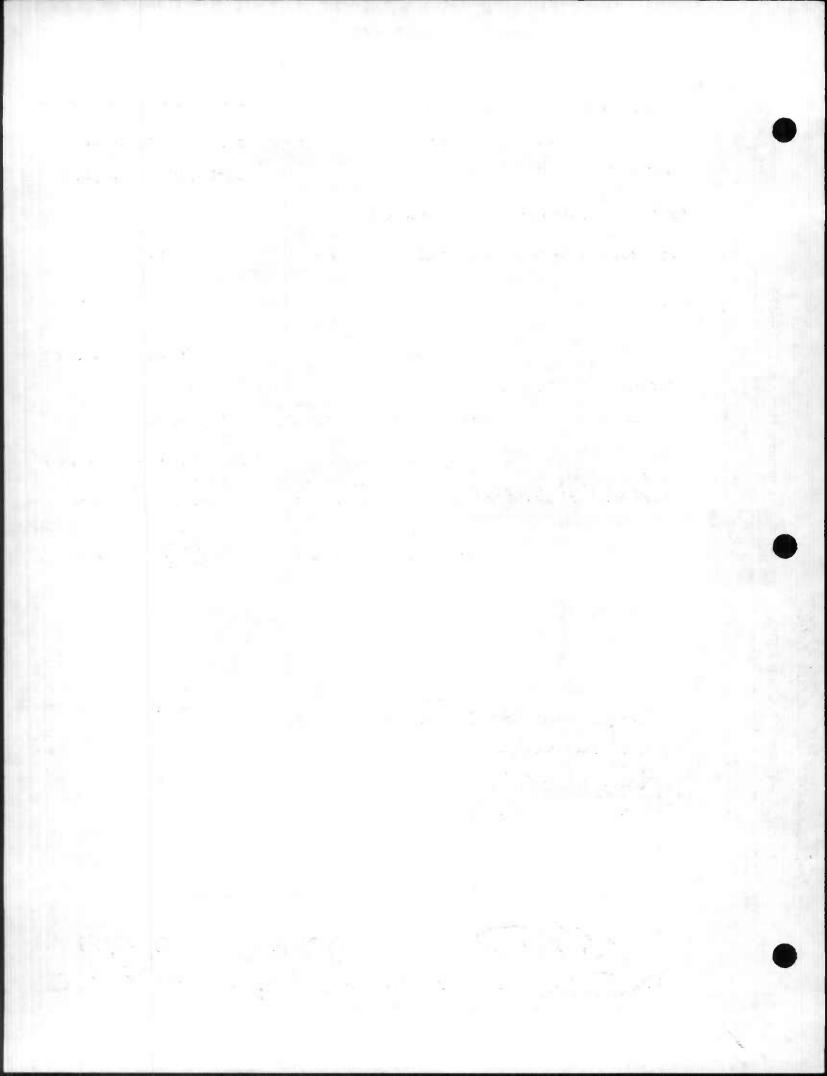


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Deta of Daath 3. Time of Deeth 1. Decedant's Nama (First, Middle, Last) Month **Physician** Raymond Allard Stallknecht /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) **Examiner** Washington County Hospital If Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Month, Dey, Year) Hagerstown Washington 5. Socief Sacurity Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months 1X M 2□ F Yrs. 218-07-8290 92 Director August 1, 1906 Maryland Usual Rasidanca of Decedent with the Maryland 10a. Steta 10b. Count 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23e or 28e-f shot treumstic event, the Medical Examinal must be notified as Maryland Washington Boonsboro 1 ☐ Yas aE No Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 8507 Mapleville Road Apt. 2102 21713 USA parm. Pages 1 and 2 should be filed within 72 hours efter death a Desaftment of Health and Mental Hyglena. Important: If Item 27 Is marked other than "natural", or items 23 my Injury or other treumatic event, the Medical Execution main Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Dacadani of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American indien. Bleck, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No if Yas, Giva Yaer or Datas: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decadant's Usuel Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Officer Insurance Company 18. Mothar's Nema (First, Middle, Maiden Surneme) 17. Fathar's Nama (First, Middle, Last) Raymond A. Stallknecht Clara Ida Allard 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Raiationship (Type, Print) Charles Roebuck Nephew 5616 St. Albans Way Baltimore, Maryland 21212 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Parkwood Cemetery 3/23/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22 Nama and Addrass of Facility. Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enjer the disease, or complications that caused the deeth. Do not aniar the mode of dying, such es cardiac or raspiretory errasi, shock, or heert feilure. List only one ceuse on each line. Approximata intarvel Batween Onset and Daath **Physician** wall accide /Medical Immediata Ceusa (Final disaesa or condition resulting in death) Examiner Examiner attending physician end for use as the burial-transit requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Diseasa or Injury that initieted avants rasulting in daeth) Lest Dua to (or es e consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 28 No 3 Probably 4 Unknown p 24b. Ware autopsy findings availabla prior to complation of cause of daath? Completed 24e. Was en eutopsy page 2 has 10 1 Yas 2 No certificate or Attending Physician: director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 □ ER/Outpailant 3 □ DOA this funeral 27. Mannar of Deeth 28d. Dascribe how Injury occurred 28b. Tima of 28a. Data of Injury (Month, Dey Year) 28c. Injury et Work? After t 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No invastigation 2 Accident Director: 6 Could not be determined 3 Suicida 28a. Place of injury - At homa, farm, straet, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled in 10 Cartifying Physician: To tha best of my knowladga, daath occurred et tha time, dete and piece, and dua to tha causa(s) end menner es steted.
2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date end placa, and dua to tha cause(s) end manner statad. edicai 29a. Certifier (Check only one) 29d. Data signad (Month, Dev. Yeer) 29b. Signatura end iiile 29c. Licansa number who complated causa of daath (Itam 23a) (Type, Print) 40xleur MAR 2 2 32. Regisirar's Signatura State 1999 Registrar

DHMH 16 Rav 6/95



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

-	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

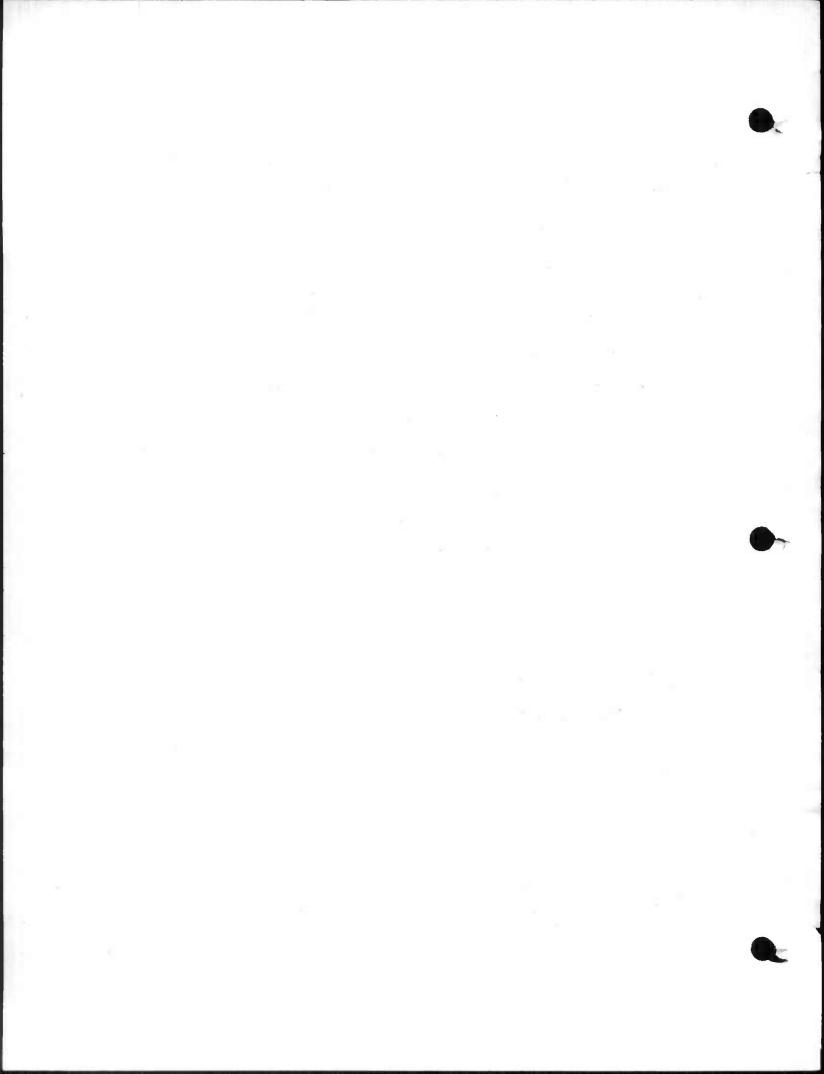
IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1. DECEDENT'S NAME (First,	Middle, Last)							2. DAT	E OF DEATN			3. TIME OF DEATH	
	Archie Lee	Shorte	er										0600 M	
	4. SOCIAL SECURITY NUME	ALSECUMENT NUMBER SEX S. AGE (in yra last perioday) FUNDER 1912 MARCH 17			IPLACE (State or Foreig	ign								
	213-36-2714		1 🖾 M 2 🗌 F	59	YRS.	MONTHS DAY	S HOURI	MIN,	Nov	7. 10.1	939	We		nia
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TOV	N OR LOCA	TION OF DE						
R	122 Cumber	Land St	t.			C1	ear S	pring	7		W	ashi	ngton	
DIRECTOR														
R	10a. STATE				10c. CITY,								10d. INSIDE CITY LIMITS?	
			ngton			CT	ear S	pring	5				1 X YES 2 NO	0
₹.			a .				101. ZIP CC				10g. CIT			
FUNERAL		cland :						2172	2.2			USA		
Ξ	11. MARITAL STATUS	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF	MED NO	13. WAS	DECENDENT	OF HISPAR	NIC ORIG	IN? (Specify Yea	or No-	14, RACI Black	E — American Indian, k, White, atc.	,
В	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES		1 🗆	YES 2 X N	O Specify	fy:			Spec	white	
	15. DEC	EDENT'S EDUC	CATION	16a. DE	CEDENT'S U	ISUAL OCCUE	ATION		16	P KIND OF BIR	INESS/IN	DIETEV	WILLE	-
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PLE		-12)		+)		wel.	ler			met	al			
O	17. FATNER'S NAME (First, M	iddle, Last)					18. MC	TNER'S NA	AME (First	Middle Maiden	Sumamel			
U U	Durward Sho	orter					- 1				ournama,			
@	19a. INFORMANT'S NAME (7	ype/Print)		19	b. MAILING /	ADDRESS (Str	et and Numi	per or Rural i	Route Nu	mber, City or Town	n. State. Zh	Code)		\dashv
2	Dorothy Wya	and Sho	orter -										21722	
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			ovet from State	Rose	metory or oth	er plece) Ceme t	erv	3.	-19-	99 Ha	gersi	town.	Maryland	1
	21, SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	- 1 1000	4	22. NAM	E AND ADDI	RESS OF FA	ACILITY	MINNIC	UIT H	VER AT	HOME	
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	resulting in death)	→	a. DILATE	ED CAR	DION	176 11	לאון						YEARS	
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Sic	1 YES 2 HO			ER/Outpatient 3	□ DOA	OTHER: 4 - Nursing	lome 5 🕾	Residence	8 🗆 Ott	ner (Specify)				
PHYSICIAN:	27. MANNER OF DEATH						INJURY AT		28d. D	EŞCRIBE NOW I	NJURY OC	CURED		\neg
ВУ								□ NO						_
	3 Suicide 6		28a. PLACE (building,	F INJURY At he atc. (Specify)	me, farm, at	reat, factory,	iffica				nd Numbe	r or Rural I	Route Number,	
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COMPLETED	onel) and manner as state	led.
	29b. SIGNATURE AND TITLE	OF CERTIFIER	?				29c. L	CENSE NUI	MBER		29d DAT	E SIGNED	(Month, Day, Year)	-
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2	30. NAME AND ADDRESS OF	PERSON WN	O COMPLETED CAU	SE OF DEATN (ITE	M 27) (Type: I	Print)	J	- 10	, -			- 1	. /	\dashv
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	BARRY M. CAM-													
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

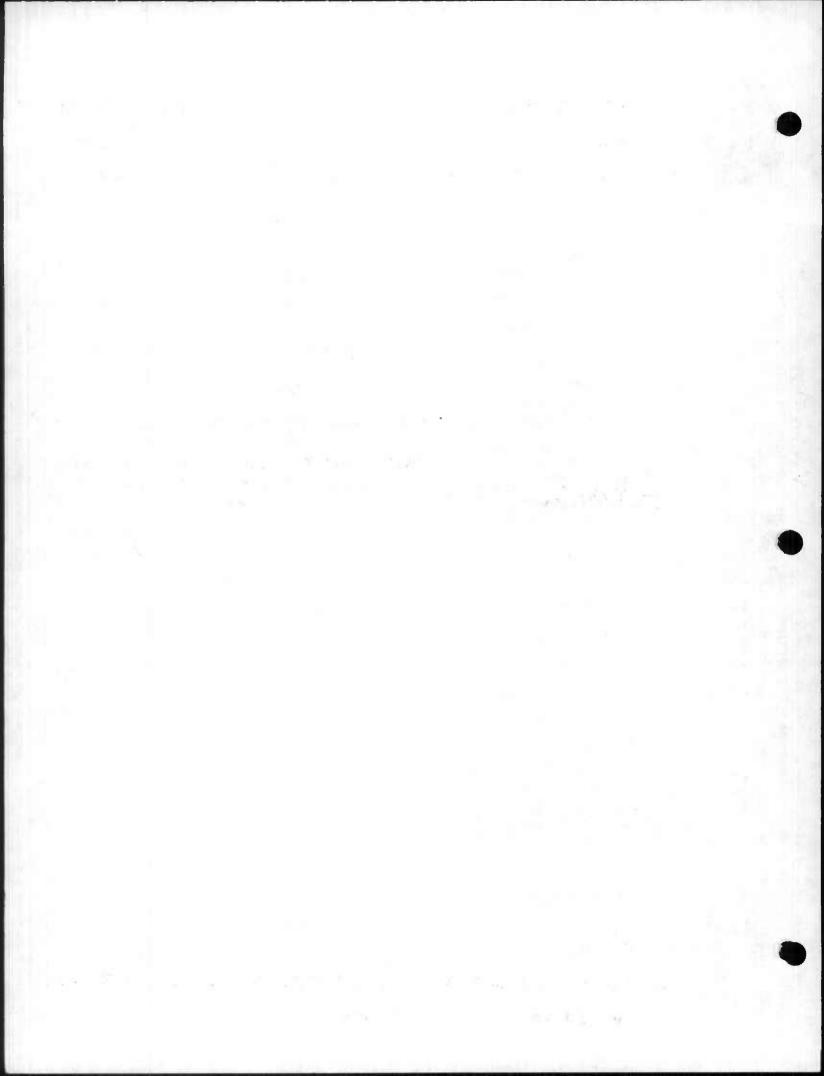
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

10745

			1. Decedent's Name	(First, Middle, Las.	t) .						2. Dete of De			3. Time of Deeth	1
	Physici /Medi		Vivian	Adele Sc	hmidt						Month	h 19, 1	9 9 9′	11:30	P
	Examir		4a. Fecility Nema (If r	not institution, give	straat and numi	ber)			4	4b. City, Town, or L	-L		y of Death		_
1			REEDERS	MEMORIAI	L HOME					BOONSBOR	RO	W	ASHINO	TON	
	_c Funeral		5. Sociel Security Nur			. Age (in yrs. la	st birthday)	If Undar Months	1 Year Days	If Undar 24 Hrs. Hours Min.	8 Date of Bir	th			ign
	Director		506-16-5	OUT	□M 2⊠F	80	Yrs.	Moritina	Days	Flours Will.	NOV . 5	, 1918	NE	leca (Stata or Forei try) BRASKA	
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4	28a-f	Director	MARYLAND 10e. Street and Numb	WASHING	TUN			104 7		OONSBORO					-
4	on with the Maryla 23a or 28a-f should be notified at				m Eron			10f. Zip	Code	01710		10g. Citizen of			
4	oean win ine mayand ma 23a or 28a-f show	era	141 SOUT	H MAIN S.	LREEL 12. Was Dacad	ent Ever in II S	12 1	Nas Dagg	dont of H	21713	ooih. Voo or Ne	14 Pa	U.S.A		
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21215-0020	1, or	by	3 ⊠Widowed 4		If Yes, Give Yeer or Data		1	□ Yes :	2⊠ No	Specify:		Specia	y: Ta	HITE	
2 5	"natural",	ted		5. Decedent's Edu	cation		16e. Deced	ent's Usue	el Occup	etion		16b. Kind of E			
215	, and	Completed	(Specify Elementery/Second	only highest greatery (0-12)	le complated) College (1-4	lor 5+)	(Give I life. D	kind of wor OO NOT us	rk done d se retired	during most of work	aing				
T		Con	12		00.090(1			SEA	AMST	RESS		SELF-	EMPLO	YED	
	< 0 m 9	Be (17. Father's Neme (F	irst, Middle, Last)						18. Mother's Nam	e (First, Middle	, Maiden Sumei	na)		
× 10	markad o	Lo	FOREST L.	STONE						IVALU I	ONGSTRE	ETH			
lar de C	and and lis ma		19a. Informent's Nam							end Number or Rur				Code)	
	of Health and Ment item 27 is markac other traumetice		LINDA L.		ER/DAUGH					GROVE RO	AD, KEEI	DYSVILLE	E, MD	21756	
more			20e. Method of Dispo-	sition Crametion 3 ☐ F	Removel from St		ca of Dispos netery, crem	sition (Nen ne <i>tory</i> or o	ne of ther plea	re)	Deta	20c. Location	- City or To	wn, State	
			4 Donetion 5	Other (Specify)			HSBUR	G CRI	EMAT	ORY 3/	20/99	SMITHSE	BURG,	MARYLAND	1
Bailt	Department of Important: If any injury or once.		21. Signature of Pyne	erei Service Liveria						ss of Facility	7606 01	ld Natio	nal F	ike	
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	hysician									1				Onset end Death	
	/Medical xaminer		Immediate Ceuse (Fli disease or condition	nel	cer	eliro -	men	ulu	n .	under	1				
		<u>.</u>	resulting in death)				s e consequ		-					-com	
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D è	200	Siet									perfo	rmad?	con	ilable prior to npletion of causa leeth?	
	ate hes	Completed										100 000			
Or Vital	certificate rector, pag		25. Wes case referred	to medical						26 Dinas of Day	10	,	1	Yas 2 No	
Physician:	is certific director,	0	exeminer?	-	lospital: 1 ☐ Inp	atient 2 ==	3/Outpetient	3□ DO	Othe	26. Plece of Deat		one) dence 6 □Oth	or Caret	1	
2 4	€ 20	-	27. Menner of Deeth		28a. Dete of I (Month,		8b. Time of		8c. Injury Work			now Injury occur		/	-
DIVISION or Attending	ath. r: After ne funer	atio	1 Naturel 2 ☐ Accident	5 Pending investigation	(Month,	Dey rear)	Injury	М		<br Yes 2 □ No					
VIS Atte	ofter deat Director: I in by the	tific		6 Could not be determined	28e. Piece of	Injury - At home , etc. (Specify)	e, ferm, stre	et, factory	, office		28f. Location (Street end Numi	ber or Rural	Route Number,	
2 2	al Direction by	Certification:	, _ Hornolde		bullaing,	, әкс. (эреспу)					City or Tov	vii, 3(818)			
ospit	uner.		29a. Certifier 14	Certifying Phys	ician: To the be	est of my knowle	edge, deeth	occurred e	et the tim	e, dete end plece,	end due to the	ceuse(s) end m	anner es ste	eted.	
To the Hospital	within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		/		and manner	stated.	and/or inve	estigetion,	іп ту ор	pinion, death occurr	ed et the time,	dete end piece,	end due to	rne cause(s)	
Po	To	Σ	29b. Signeture end titi	e of certifier	,			29c	. License	number		29d. Date signe	d (Month, E	lay, Year)	
			N	Luch	1 Mh			1	03	2518		3/20/9	5		
-			30. Neme and eddress					rint)				/			
			Dr. Robe	ert Guede	net 100	Geetin	g Lan	e, Ke	edys	sville, M	laryland	21756	/ (30	1) 432-2	22
	-		31 Data filed /Month	Day Vagel	20 0	Intends Cianas									

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 10746

217 W. Washington St. Hagerstown, MD

					Ce	rtificate c	of Death		Reg. N	0.		
III.		1. Decedent's Nama (First, Middla, L.	ast)					2. Data of De			(0.0.1	3. Tima of Death
Physi /Med		TIMOTHY JO	OHN ST	TANDI	LEY			Month	21		/aar	9:20 PM
Exam		4a. Facility Nama (If not Institution, gi	a straat and number)			4b. Cify, Town, or			c. County of	Deeth	
		Washington Coun	tv Hospita	al			Hagersto	own		Was	hing	iton
Funera	af .	5. Social Security Number 6.	Sax 7. A		last birthday)	if Undar 1 Ya Months Da		8. Data of Birt	ih Yaa	, 9		ica (Stata or Foreign
Directo	r	585-98-6581 Usual Rasidance of Dacadant	X XM 2□ F	35	Yrs.	WORKIIS DE	ys 110018 14181.	8. Data of Birl (Month, Da May 18	, 196	53	Tex	as
laryland show		10a. Stata 10b. County		10c. City	y, Town or Lo	ocation					100	d. Insida City Limits
Ma office	Ş	Maryland Washin	gton		Hac	erstown						1XXYas 2□No
th th	<u>5</u>	10e. Street and Number				10f. Zip Cod	е		10g. C	itizan of Wh	at Countr	y?
23a	a C	521 Maryland Ave	nue			2	1740			US	A	
d within 72 hours after deeth with the Maryland plens. I than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas VXYas 2 ☐ If Yas, Giva Yaar or Datas:	? No 198	87-	Was Decedant of the Yas, specify C	of Hispanic Origin? (Suban, Maxican, Puar No Specify:	Specify Yas or No to Rican, atc.)		Specific	Amarica Whita, at	c.
natura natura	Completed	15. Decedent's E (Specify only highast gr		19	16a. Dece	dant's Usual Oc kind of work do	cupation ne during most of wo lired)	rking	16b. i	Kind of Busi		
d within 72 hours af glena. rr than "natural", or r a Mevical Exam	E	Elementary/Secondary (0-12)	Collaga (1-4or	5+)					٥-	tate P) n 1 - 0	
e filed al Hygle other		17. Fathar's Nama (First, Middla, Las.	4		COFFE	CITOHAI	Officer	ma (First, Middla,				·II
of other	Be	i i	, Standley						eek	ii Sumama)		
s 1 and 2 should be filed with f Haalth and Mental Hyglena. tam 27 is marked other than other traumatic event, me.	2	19e. Informent's Name/Ralationship			10h Maili	na Addrana /Ctr				or Town Co	nate Zin (2 of al
						_	eet and Number or Ri					21740
1 an Heal		Roberta R. Stand	rey/wire	20h. P		osition (Nama of	nd Avenue	Data		ocation - Ci		
nt of hit it it it		1 □ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Speci	Ramoval from Stata	C C	ematary, cra	matory or othar	place)					
It. P	۵	21. Signature of Funeral Service Lice	-	MT.		Cemeter		3-25-99	Shar	psbur	g,Ma	ryland
permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any Injury or other tra		1 -11					trass of Facility Ho		1 1.7			L ND 0170
_		23a. Part 1. Entar the disaasa, or con	polications that cause	d the death			nococheagu			IIIIam		T, MD Z1/9 Approximata ntarval Batween
Physiciar /Medica Examine	i	Immediata Causa (Final disaasa or condition rasulting In death)	a. Gunsh		ound t		and Abdo	men	_		mo	oments
entificate be executed ding physician and se as the burial-trensit		Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying		Dua to (or	r as a conse	quance of):					1	
ificate be axe g physician a as the burial-	Medical	Causa (Disaasa or Injury that Initiated events rasulting in daath) Last	C. ———	Dua to (or	as a consec	juance of):					-	
leath certifica attanding pt d for usa as t			d									
the death y the atter sched for u	Physician	Pert II. Other significant conditions	contributing to death b	but not rasu	ilting In the ii	ndarlying causa	given In Part I	23b Did i	tobacc	o use contr	lbute to t	the cause of death?
that the de ned by the s detached		and the second control of the second				, , , , ,				V.		ably 4 Unknow
aw requires as been sign 2 should be	Completed by							24a. Was perfo	en euto	opsy	com	e autopsy findings lable prior to pletion of causa path?
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	Be	25. Was casa referred to medical					26. Place of De	ath (Check only o	na)			
\$ 00	To	axaminar? 1፟፟ Yas 2 No	Hospital:	ant 210	ER/Outpatie	nt 3 DOA	Othar: 4 Nursing H	Homa 5 ☐ Rasio	dance	6 Othar	(Specify)	
		27. Mennar of Death 1 □ Natural 5 □ Panding	28a. Deta of Inju	ury av Year)	28b. Tima o Injury	f 28c. I	njury at Vork?	28d. Dascribe t	now Inju	ry occurred	1	
Attanding r death. ector: Afta by the fune	atic	2 Accidant invastigatio	March 21.		9:20	РМ	☐ Yas 2 No	self inf	lict	ed guns	hot w	ound to che
	ertification:	3 ☑ Suiclda 6 ☐ Could not b 4 ☐ Homicida detarmined	28a. Placa of In building, a	jury - At ho tc. (Spacify	ma, farm, st	aat, factory, offi	08	28f. Location (\$ City or Tox	vn, Stat	a)		
Hospital 4 hours Funeral taly filled	edical Co	29a. Cartifiar (Check only one) 1 Certifying Pr	At Honorysician: To the best ninar: On the bests of and manner st	of my know	vladge, deat ion and/or in	n occurrad at the vastigetion, in m	a tima, data and place y opinion, death occu	521 Mar e, and due to tha urred et the time,	causa(and mann	ar as sta	tad.
Vithin 2 To the comple	Me	29b. Signature and titla of certifiar					ansa number		29d. D	ata signed (Month, Da	ay, Year)
		I chual u), D.	Acoc		_ DO	01062		Mar	ch 23	, 199	99

State Registrar 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

M.D.

Edward W. Ditto, III, 31. Dete filed (Month, Day, Year) MAR 2 5 1999

Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sybarina S. Sparrow 1115am March 1999 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Jan. 2, 1911 5. Social Security Number 7. Age (fn yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2₽F 88 Yrs. Washington D.C. Director 247-54-2871 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23s or 28s-f shore Examiner must be notified at 1 X Yes 2 No Director Maryland Washington Boonsbore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 141 South Main Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forcas? should be filed within 72 hours effer and Mental Hygiene.
marked other than "natural", or its unrade svent, or within an area. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemkaer Unknown Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other traumatic svent, page. 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Phoebe Young Henry Stanley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennie Amer/ Niece 420 Gun Club Rd. Hockessin, Delaware 19707 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State Rest Haven Cemetery Mar. 13, 1999 Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility Donald E. Thompson Funeral Home Inc.

P.O. Box 310 Clear Spring, Maryland 21722

234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Premaria 2 wont Examiner Due to (or as a consequence of): Examine physician and the bunal-transit Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): certificata be Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Tonknown 3 Cellula Anomic will Algherin Dinean Records, ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has bringertor, pege 2 st eged 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury et Work? Division 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier - total mo march 12,1959 D (8015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown 334 Datta 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State MAR 1 8 1999 Registrar

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Darrow

NAME: SPARROW, SYBBIE STANLEY 01/02/11 88 / F St

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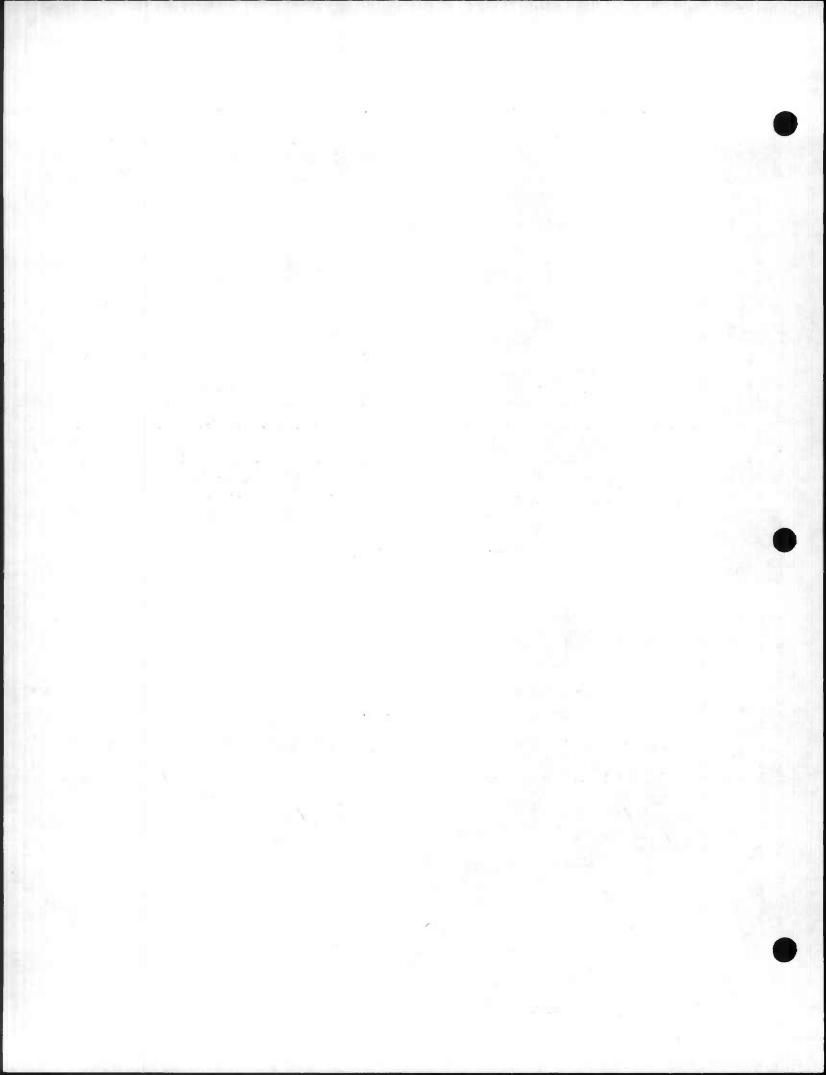
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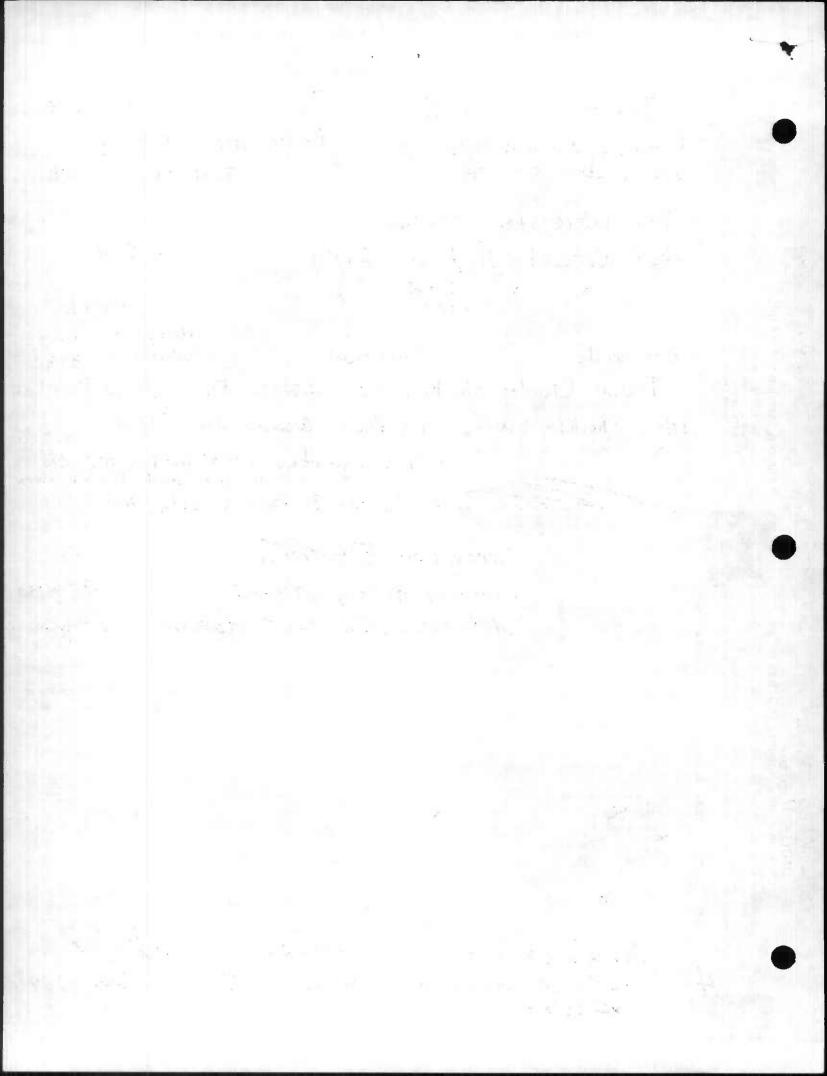
			Ce	rtificate of	Death		Reg. No.		
	1. Decedent's Name (First, Middle,	Last)				2. Dete of D			3. Time of Death
Physician	Roy Elwood SEMI	ER. SR.				MARCH	10. 1	999	12:15 PM
/Medical Examiner	4a Facility Name (If not institution,	-	er)		4b. City, Town, o	or Location of Dee			12.13 111
Examine	RAVENWOOD LUTHE	DAN WITTA	CE		HAGERS	TOLIN	MACH	INGTO	N
			Age (In yrs. last birthday)	If Under 1 Year					
Funeral Director	214-09-6609 Usuel Residence of Decedent	1₩ 2□F	84 Yrs.	Months Days	Hours M	_	7 1914	Mary	ace (Stete or Foreign ry) land
ehow rd.at	10a. State 10b. County		10c. City, Town or L	ocation			-	10	d. Inside City Limits
Director		ngton	Sharps						1 ☐ Yes 2☐ No
	10e. Street and Number			10f. Zip Code			10g. Citizen of \		ry?
uneral	17350 Shepherds			217		/a // //	U.S.		- tadia
by Funeral	11. Marital Status 1 Never Merried 2 Married 2 Never Merried 2 Married	If Yes, Give	No	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No		(Specify Yes of Nerto Rican, etc.)	Blee Specify	ca - America ck, White, e	tc.
D D	3 ¼ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dete		dent's Usuel Occu	nation		16b. Kind of B		ite
Set	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of w	vorking	TOD. KING OF S	03111633/11100	ustry
Completed	Elementery/Secondary (0-12)	College (1-4-	or 5+)	Moulder			Sand B1	act M	fo
ŏ	17. Fether's Neme (First, Middle, La			TOUTUEL	18. Mother's N	lame (First, Middle			-5.
To Be C	Harry H. Semler					e Shrade			
ř	19a. Informant's Name/Reletionship		19h Mail	ing Address (Stree				State 7in I	Code)
								, 0,010, 2.40	0000)
	Laura Semler Va	ughn P.O	20b. Plece of Disp	Box 524 osition (Name of	Emmits	burg, Md	• Z1 / Z / 20c. Location -	City or Toy	vn. Stete
	1∑ Burial 2 ☐ Cremetion 3		comptony cro	metory or other ple			No. of the		
	4 Donation 5 Other (Spe			w Cemeter	-	3/13/99			Maryland
9000	21. Signeture of Funerel Service Lic	ensee		2. Name end Addr		Minnich			
a	fred L.	Vestel	4	15 E.Wils	son Blvd	. Hager	stown, M	aryla	nd 21740
an	23a. Pert1. Enter the disease, or co shock, or heert feilure. List or	implications that cau ly one cause on eac	sed the death. Do not en h line.	iter the mode of dy	ing, such as card	iac or respiretory	errest,		Approximete Intervel Between Onset end Death
lical	Immediate Cause (Final	CARC	INOMA OF LT.	LUNC					2 MONEILO
er	disease or condition resulting in death)	8	Due to (or as a conse					1	3 MONTHS
ě			Due to (or as a conse	querice or):				1	
Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or es a conse	quence of):			T N	1	
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	C	Due to (or es a conse	quence of):					
Physician/M		d							
tached for use	Pert II. Other algnificant conditions	contributing to deat	h but not resulting in the u	underlying cause g	iven in Pert I.	124			the cause of death?
	DEMENTIA OF AL	ZHEIMERS 7	TYPE, OLD CE	REBRAL T	HROMBOSI	S 1	Yee 2□No	3 Prob	ebly 4 ☐ Unknowr
should be d							s an autopsy	24b. We	re eutopsy findings
should beted	ARTERIOSCLEROT	IC HEART I	DISEASE, ATR	RIAL FIBR	ILATION	per	formed?	ava	iliable prior to
Completed	PERIPHEAL VAS	OIII AD DEGE	FACE			45	Yes 2 No		leath?
		OOLAK DISI	LASE					10	Yes 2/2 No
Be	25. Wes case referred to medical examiner?	Hospitel:		.= 0	thor .	Deeth (Check only			
ို	1 ☐ Yes 2 Ø No 27. Manner of Death	1 L Inp	atient 2 ER/Outpatie	MI 3LI DOA	4 /Z Nursing	Home 5 Res	how injury occur)
atlon	1 Netural 5 Pending investige		Day Year) 285. Time of Injury	Wo	ork? Yes 2 No	200. Describe	s now injury occur	red	
Certification:	3 Suicide 6 Could no 4 Homicide determine	28e. Plece of building,	Injury - At home, ferm, st etc. (Specify)	treet, fectory, office		28f. Location City or To	(Street and Numi own, State)	ber or Rural	Route Number,
edical (29e. Certifier 12 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	est of my knowledge, deel s of examinetion and/or in	th occurred et the to	ime, date and pla opinion, deeth oc	ce, end due to the courred et the time	e cause(s) and m e, date end plece,	enner es sta and due to	ated. the cause(s)
completely filled in by	29b. Signature and title of certifier	one meaning	,0	29c. Licen	se number		29d. Date signe	ed (Month, E	Day, Year)
D		last has	(hel)	DO	7857		MADOII 1	1 10	00
	On Name of Addition	ed freeza	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		1001		MARCH 1	.1, 19	99
	DR. EDSON MOODY		of death (Item 23a) (Type O MT. AETNA		GERSTOWN	I, MD. 2	1740		
State	31. Dete filed (Month, Day, Year)	32. Red	strar's Signature						
Registrar	MAR 12	1999	D	· popor	les				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item #18, 3/29/99, E.T. WCHD 2 Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 99 6:30 a. 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Berlin Worcest Md 7. Age (In yrs. last birthday) Teneral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-13-5 Birthplace (State or Foreign Country) **Funeral** Months Days 49 15M 20 F Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 Yes 2 No **Funeral Director** orces 6 10g. Citizen of What Country? 10a Street and Number 8028 18 12. Was Decedent Eyer in U.S.
Armed Forces?
10. Yes 2 No 9 -18-68
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. marked other than "natural", or items 11. Meritai Status 1 Never Married 2 Married 1 ☐ Yes 2 1 No Black by Year or Dates: Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Worcester Elementary/Secondary (0-12) College (1-4or 5+) Scriag 12th grade Nater permit. Pages 1 and 2 should be file Department of Health and Mentel Hy important: If Item 27 is marked othe any Injury or other traumetic event, page. 18. Mother's Name (First, Middle, Maiden Sumeme) Dorothy 17. Father's Nerge (First, Middle, Last) Be harles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Box Shockley Nework 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Paul Come,
22. Name and Address of Fecility Berlin 3-27-99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie BenNie Box 331 Pocomula City, md. 21851
e mode of dying, such es cardiac or respiratory errest,
Approximate P.O. Box 331 Approximete Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that ceused the deeth. Do not shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last that the death certificate be Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? 24e. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 🗆 No 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Division Attending 5 Pending Investigation 1 Yes 2 No 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò To the Hospital o within 24 hours af To the Funeral Dicompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

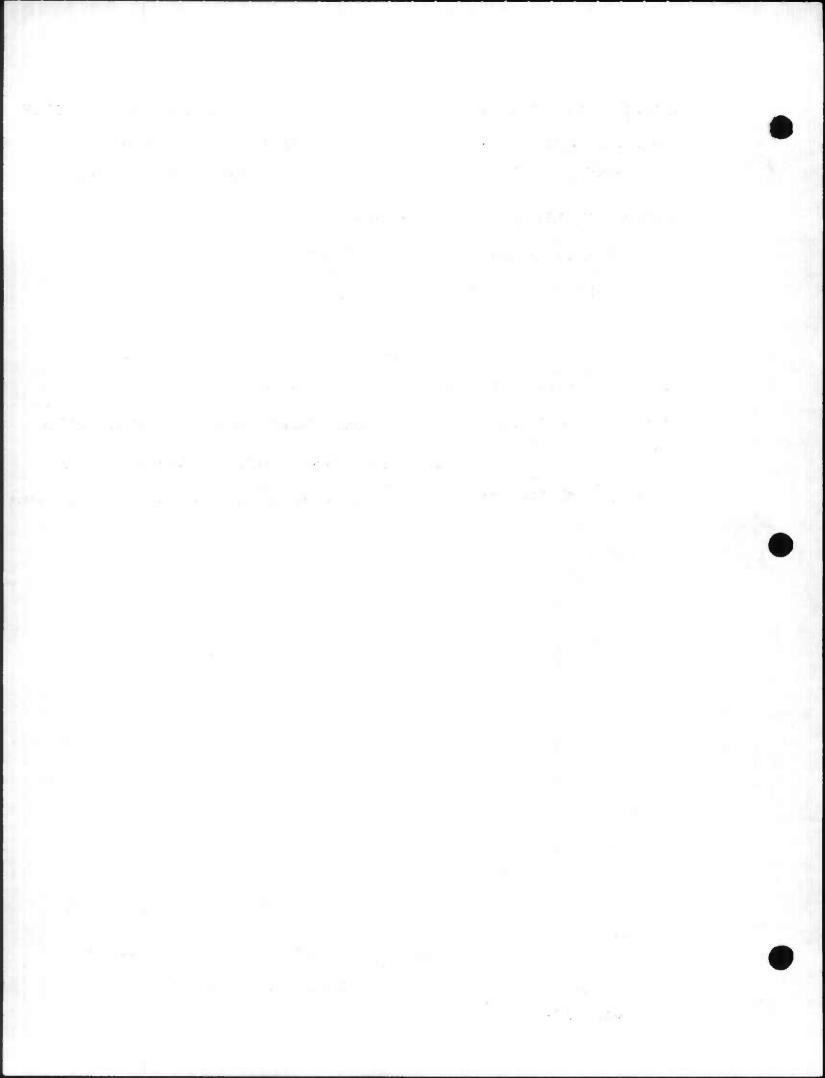
2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Neme and ad m 23a) (Type, Print) 400 Eastern Shore drive Lay State Registrar

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				olale of Marylan		ertificate			-	Reg. No.		0750
	61		1. Decedant's Nama (First, Middla, Last)						2. Data of De		Yaar	3. Tima of Death
	Physici /Medic		GLORIA LEE T	OSTEN					March	21, 19		5:30 PM
	Examir		4a. Facility Nama (If not institution, give stre	A COLOR OF THE PARTY OF THE PAR			4	lb. City, Town, or L				
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	Funeral Director			7. Aga (In yrs. 71,	Yrs	Months	Days	Hours Min.	8. Data of Bli (Month, Da May 7,	1927	9. Birthpi Count Mar	laca (Stata or Foraign try) yland
	puel Maria		Usual Rasidance of Decedant 10a. Stata 10b. County	10c. Cit	y, Town or	r Location					10	Od. Inside City Limits
	Mary H sh	tor	Maryland Washing	ton H	ager	stown						11/2 Yas 2 No
	or 28	lrec	10e. Street and Number			10f. Zip	Coda			10g. Citizan of V	Vhat Coun	try?
	23a	rai	312 Woodpoint Av	enue		2	174	0		U.	S.A.	
020	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinat De notified at an	by Funeral Director		Was Decedant Evar in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	l,S. 1	3. Was Deced If Yas, spec		Ispanic Origin? (Sp in, Maxicen, Puarto Specify:	pecify Yas or No Rican, atc.)	9- 14. Rac Blac Specify	- Amarica k, Whita, a · Whi	atc.
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Division	if or Attendi efter death Director: / d in by the f	Certification:	3 Could not be	28e. Place of Injury - At he building, atc. (Specif	ome, farm,	streat, factory	, office			Straat and Numb wn, Stata)	er or Rura	Routa Number,
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	- > - 0		1 Selever Pa	,271-			DO 1	062		March 2	3, 19	199
		-	30. Name and address of person who compl	leted ceusa of daath (Itan	n 23a) (Ty	pe, Print)						
			Edward W. Ditto, I			V. Wash	ingt	on St.	Hagerst	own, MD	2174	40
	Sta Registr		31. Data filad (Month, Day, Yaar) NAR 2 3 1999	32. Registrar's Signa	Hura	9. pp	ock	2				



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					Ceru	ficate of	Death		Reg. No.		
Physiciar /Medica	n	1. Decedent's Neme (First, Middle, L						2. Dete of De Month	eth Day	Yeer 1999	0130
Examine		Lola Mason Tv 4a. Fecility Neme (If not institution, g PENINSULA REG			NTER		4b. City, Town, or SALIS	Location of Death	4c. County		
Funeral Director		217-03-1565	Sex 1 M 2 F 8	ge (In yrs. las		If Under 1 Yeer Months Days			th y. Year)	9. Birthplece Country) Mary	(State or For land
. A.	- 1	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City,	Town or Local	tion				10d.	Inside City Lir
A Par	ğ	MD Worcest	er	Pocc	omoke	City					Yes 2
e not	2	10e. Street end Number		1		10f. Zip Code			10g. Citizen of V	Whet Country?	
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	by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:	2		s Decedent of es, specify Cub Yes 2 No	Hispenic Origin? (S ean, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Bled Specify	e - American I ck, White, etc.	
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Mant	0	Joshua Thomas	Mason				Elizab	eth Ann	e Ford		
ls m		19a. Informent's Name/Relationship					t and Number or R				de)
Haalt em 2 other	-	Terri Perdue (20e. Method of Disposition	Daughter	20b. Plac	ce of Dispositi	on (Neme of	St. Po	comoke,	MD 21 20c. Location -		State
y or o		Burlel 2 Cremetion 3	Removal from State	cem	netery, cremet	tory or other pla	· 1				
ortan Injur	-	21. Signeture of Futherel Service Lice	**	FILE		otist (03/20/9	9 POCO	moke,	MD 2
Depa Impor		michael Do	ean moll	29			H	olloway			
	7	23a. Pert1. Enter the diseese, or cor shock, or heart failure. List only	mplications thet cause	d the death.	Do not enter t	the mode of dy	en Ave. Ing, such es cardia	c or respiratory e	rest, MD	Ap	proximete erval Between
nysician Medical xaminer		Immediate Ceuse (Final disease or condition resulting in deeth)	e[TERAL	BR	MIN IN	FARCT			WEEK
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217-03-1565

FROM LEADING AT 12 A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Earl Bailey WOLFINGER 2000 1999 march /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c/County of Desth Examiner Washington County Hospital Washington Hagerstown If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₺M 2□ F Months 80 219-12-2362 Jan.14,1919 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23s or 28s-f show 1 Yas 2 No Washington Hagerstown Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 366 Central Avenue 21740 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Black, Whita, atc. Pagas 1 and 2 should be filed within 72 hours after of the fact of Health and Mertal Hygiena.
Int: If them 27 Is marked other than "natural", or fleaturally or other traumatic avant, the Medical Environment or or other traumatic avant, the Medical Environment. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white 3⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aircraft cleaner parts Unknown 17. Fsther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Wolfinger Emma Bailey 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Russell L. Wolfinger - son 18465 Manor Church Rd., Boonsboro, Md. 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Department of Important: If it any Injury or o 1基 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 3-19-99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses Cotti Hemres 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Fins) diseasa or condition resulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit Sequentially list conditions, if sny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be detached 1 Yee 2 No 3 Probably 4 Unknown Hurry Fulure Records, by 24b. Wera autopsy findings Be Completed 24a. Was an autopsy available prior to completion of cause of death? performed? Aftar this certificate has 1 Yes 2 No 1□ Yes 2□ No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medicat 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury st Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

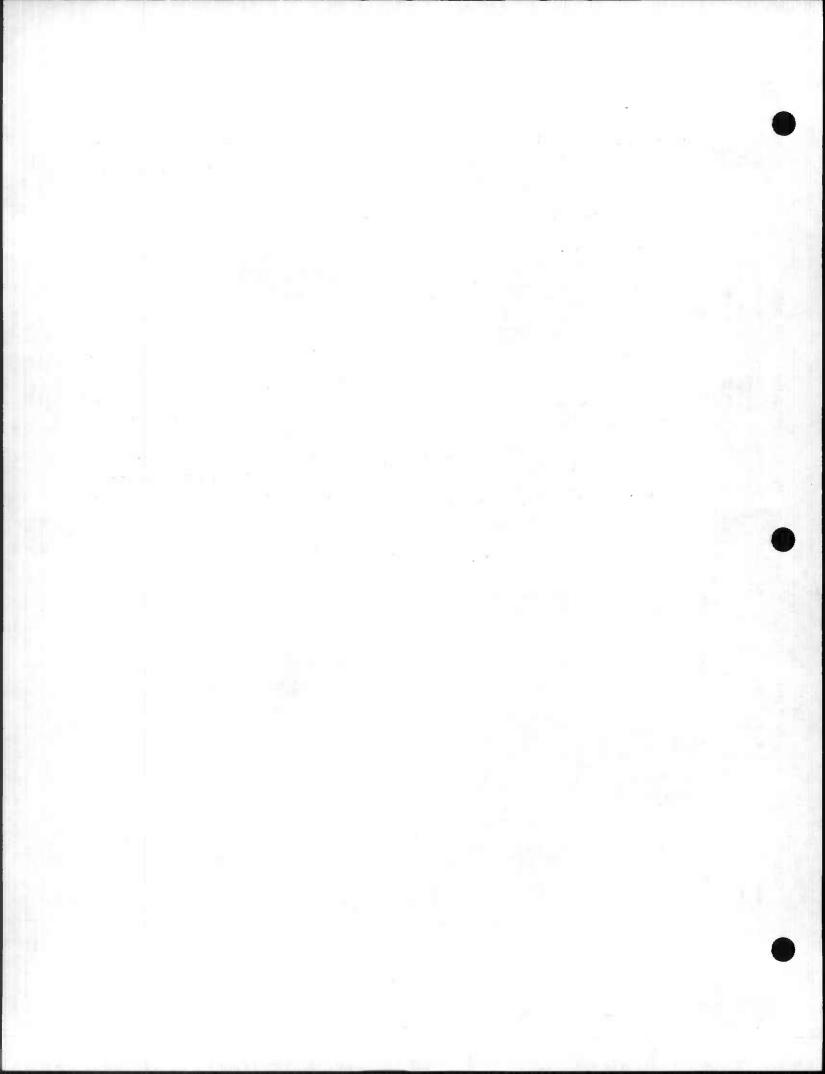
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Jufferson Bonkward Smithsburg 40 Curns 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

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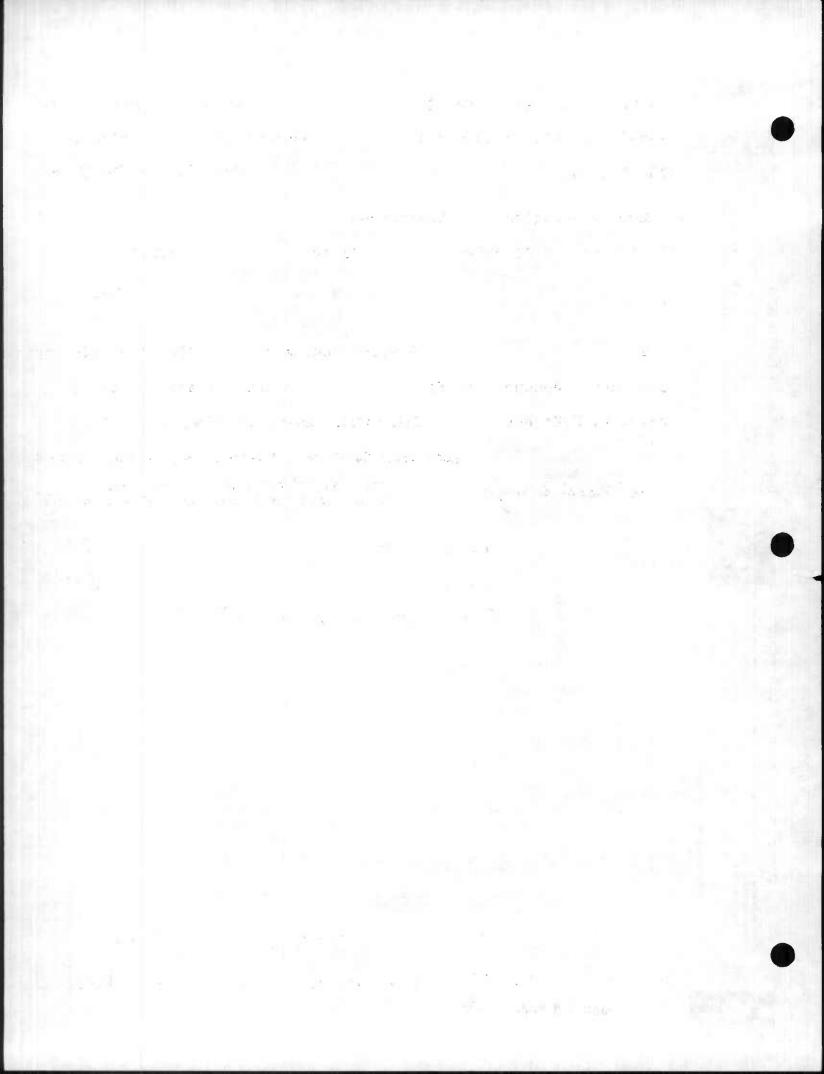
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Warch **Physician** RALPH WOLFE LAVERE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Washington County Hospital Hagerstown Washington Hagers Continued and Birth (Month, Day, Year) Hours Min.

8. Date of Birth (Month, Day, Year) Pennsylvania 5 Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Yaar 9. Birthplaca (Stata or Foreign 6 Sax **Funeral** 1 XM 2 □ F Months Days 90 Director 176-07-9083 Usual Residence of Deceden the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County tem 27 is marked other than "natural", or fems 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Washington Maryland Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 13311 Hunter Hill Drive 21742 U.S.A. death 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Service Engineer Mfg. Aircraft Engine 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy ant: If Item 27 is marked oth Clarence Eugene Wolfe Maude Irene Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 LaPlata Drive, Kettering, Ohio Hazel P. McKinney 45420 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or Injury or Rest Haven Cemetery 03 - 22 - 994 ☐ Donation 5 ☐ Other (Specify) Hagerstown. Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. & heel brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Cancon Ment /Medicai /Ung Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner NELMIN A certificate be executed bunal-tran Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): and discare Wwo Oh hum MMC Obsprehve Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequence of) 28 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera eutopsy findings available prior to complation of ceusa of daath? 24a. Was an autopsy Completed page 2 1 Yas 2 No 1 TVes 2 No certificate Attending Physician: funeral director. 25. Was cese referred to medicel examiner? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending after death. 1 Yes 2 No invastigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò 24 hours a Hospital edicai 29a. Certifier 1 🖰 Certifying Physician: To tha bast of my knowledga, daath occurred at the time, date and place, and due to tha causa(s) and mannar as stated. To the Hosp within 24 ho To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month. Day, Year) 29b. Signature and title of gertifier 29c. Licanse number 30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print)

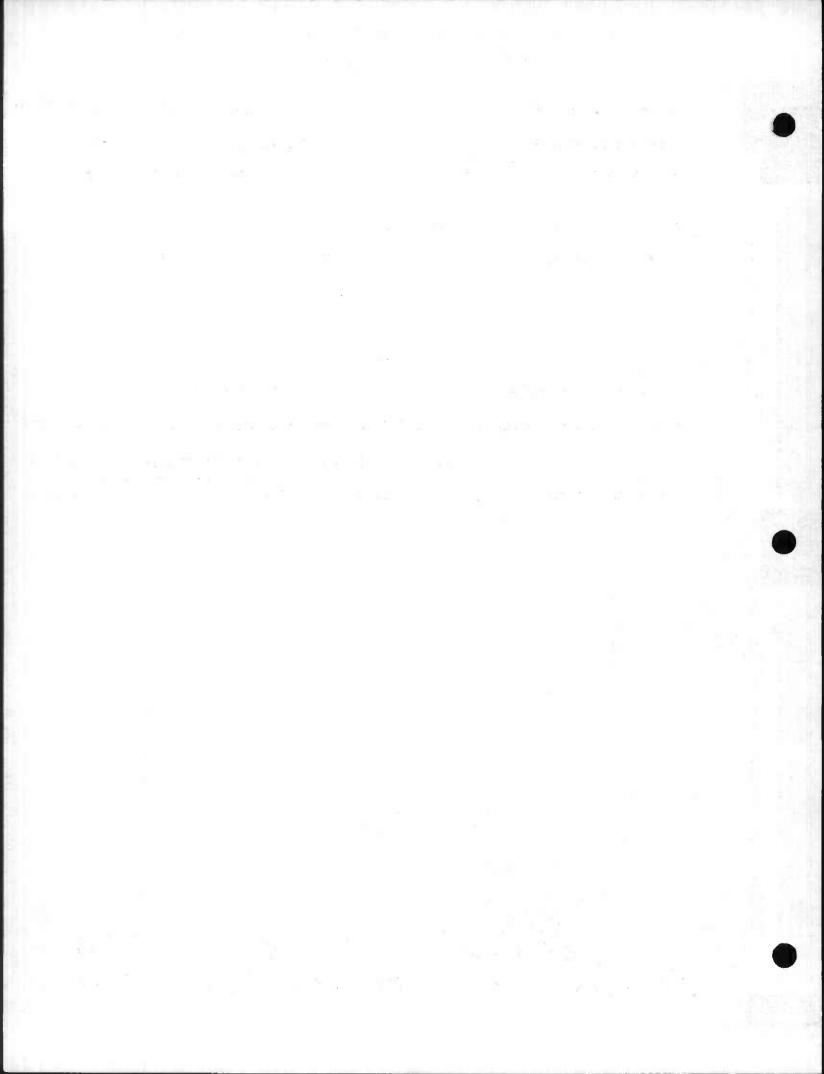
Dr. Igbal 12821 (Dak Hill Hagers town Igbal 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAR 2 3 1999 Registrar

Wolfe, Ralph lavere



State of Maryland / Department of Health and Mental Hygiene 🔘

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	Examir		4e. Fecility Neme (If not institution, give s	treet end number)			4b. City, Town,	or Location of Death	4c. County	of Deeth	
			Homewood Nursing 1	Home			Willi	amsport	Was	hingt	on
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last bin	thdey) If Under 1 Your Months De	ear If Under 24		h V Veerl		ece (State or Foreign try)
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ō	S 50 # 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emovel from Stete	cemeter	y, cremetory or other	pleca)	Dete	20C. Location	City of Tov	WII, Stele
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Baltimore,	permit. Pege Depertment Important: If any Injury or		21. Signeture of Euneral Service License	n -		23. Neme end Ad	-	Minnich	Funeral	Home	
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	Sta		31. Dete filed (Month, Day, Year) MAR 2 4 1999	32. Registrar	Signature	G. Space	K				

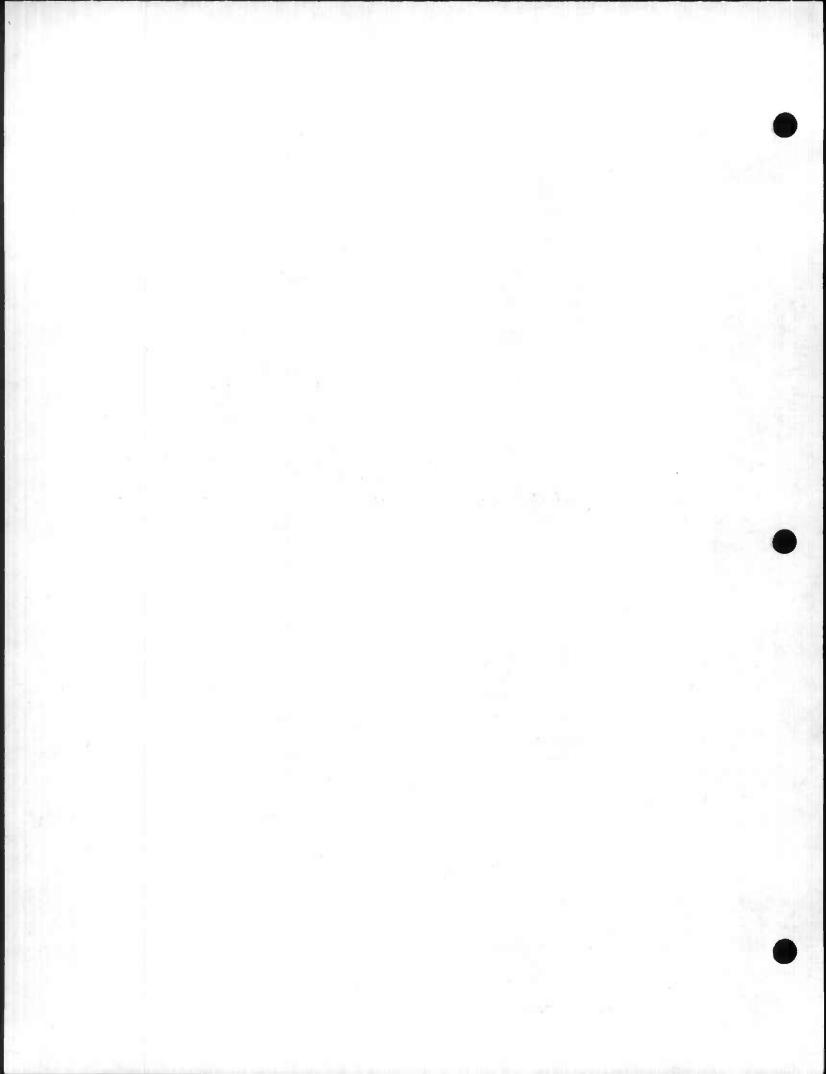


State of Maryland / Department of Health and Mental Hygiene

			Certi	ficate of	Death		Reg. No.	10/55			
Physician	Decedent's Name (First, Middle, Last) Laura May					2. Date of De Month	ath Dey	3. Time of Death			
/Medical Examiner	4a Facility Name (If not institution, give a Reeder's Memor	street and number)			4b. City, Town, or Le Boonsbo		h 4c. County	1999 3:25 PM of Death Shington			
Funeral Director	5. Social Security Number 6. Sec 217-10-3049A	7. Age (In yrs.)		f Under 1 Year lonths Days		8. Dete of Bir (Month De April	8. Dete of Birth (Month, Dev. Year) April 6, 1904 9. Birthplece (State or Fore Country) Maryland				
show show id.at	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		y, Town or Local Hagers					10d. Inside City Limit			
uth with the Maryli 23e or 28e-f sho unt be notified at rai Director	10e. Street and Number 320 West Side Aven	ue		10f. Zip Code 217	40		10g. Citizen of Whet Country? USA				
un after des af, or items Examiner in by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2Ñ No If Yes, Give Year or Dates:	S. 13. Wa	e - American Indien, k, White, etc. . White							
ed within 72 ho ygene. er then "neturn 4, the Medical J Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kin	NOT use retire	during most of work	ing	16b. Kind of Bu	clothing			
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Pages 1 and nent of Health ent if Item 27 ary or other to	20a. Method of Disposition ***PXBurial 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) **DXBurial 2 Cremetion 3 Removal from Stete **St. Paul s Cemetery 3/24/99 Clear Spr:										
Department of Important: If any or any Injury or another any Injury or a	27. Signature of Funeral Service Licensee Carald N. Minnich Funeral Home 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21										
Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
cermicate be associted anding physician and use as the burlet-fransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initileted events resulting in death) Last b. Due to (or es e consequence of): if c. Due to (or as e consequence of):										
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To the Hospital or Atlanding Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director, Medical Certification: To Be (27. Manner of Death 1 CNatural 2 Accident 3 Suicide 4 Homicide	28d. Describe	5 Residence 6 Other (Specify) Describe how injury occurred ocation (Street end Number or Rurel Route Number, 3tly or Town, Stete)								
he Hospital in 24 hours he Funeral I plately filled edical Ce	29e. Certifier (Check only one) 1 C-CEFETying Physical Examination	iclan: To the best of my knower: On the basis of examinat and manner stated.	wledge, death or tion and/or inves	curred et the ti	ime, date end plece, opinion, deeth occurr	end due to the red et the time,	ceuse(s) end me date end plece, a	nner as stated. and due to the cause(s)			
withir To th comp	29b. Signature and title of certifier	~0			se number			(Month, Dey, Year)			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 334 Mill Street, Hagerstown, Maryland 21740/301-739-7100 31. Date filed (Month, Pay, Year) 2 2000 32. Register's Signature										

DHMH 16 Rev 6/95

Registrar



D.	IANNA WASI	HINGTON	State of Maryland		rtment of h tificate of			giene 9 9 Reg. No.	10	756
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		Year 3	. Time of Death
	Physician /Medical	Diana E.	Washington				MARCH	16, 19		10:28PM
	Examiner	4a Fecility Name (If not institution, give PRINCE GEORGES H		2		4b. City, Town, or I			of Death	RGES
	Funeral Director	214-48-8665	ex 7. Age (In yrs. le	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month Da	y, Year) 2,1947	9. Birthplace Country) Maryl	(State or Foreign Land
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. srked other than "natural", or items 23s or 25s-1 show attic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		Town or Loc	calion Marlbor	0				Inside City Limits 1 No 2 No
	or 284 or 284	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
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20	ges 1 and 2 should be filed within 72 hours aftar death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examines must be notified at or other traumatic event, the Medical Examines must be notified at or other traumatic event, the Medical Examines must be notified at	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Year or Dales:		Vas Decedeni of I Yes, specify Cub ☐ Yes 2☐ No	Hispenic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Specific		
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Baltimore, I	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.	Charles Washing 20a Melhod of Disposition 1 Burial 2 Cremation 3	Removal from State	ace of Dispos metery, crem	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or Town,	Stale
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x 68760,	death certificate be executed e attending physician and of for use as the bunat-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequal						
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sion of	Attending Physical distributions of the state of the stat	27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident investigation	3166195	28b. Tima of injury	M 1	ry al ork? Yes 2 No	28d. Describe	how injury occur	hot a	behil
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	To the Hospital within 24 hours of To the Funeral I completally filled Medical Ce	29b. Signature and title of certifier		1	29c, Licen	se number		29d. Date signe MARCH	19, 1	
		100000								

State Registrar

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

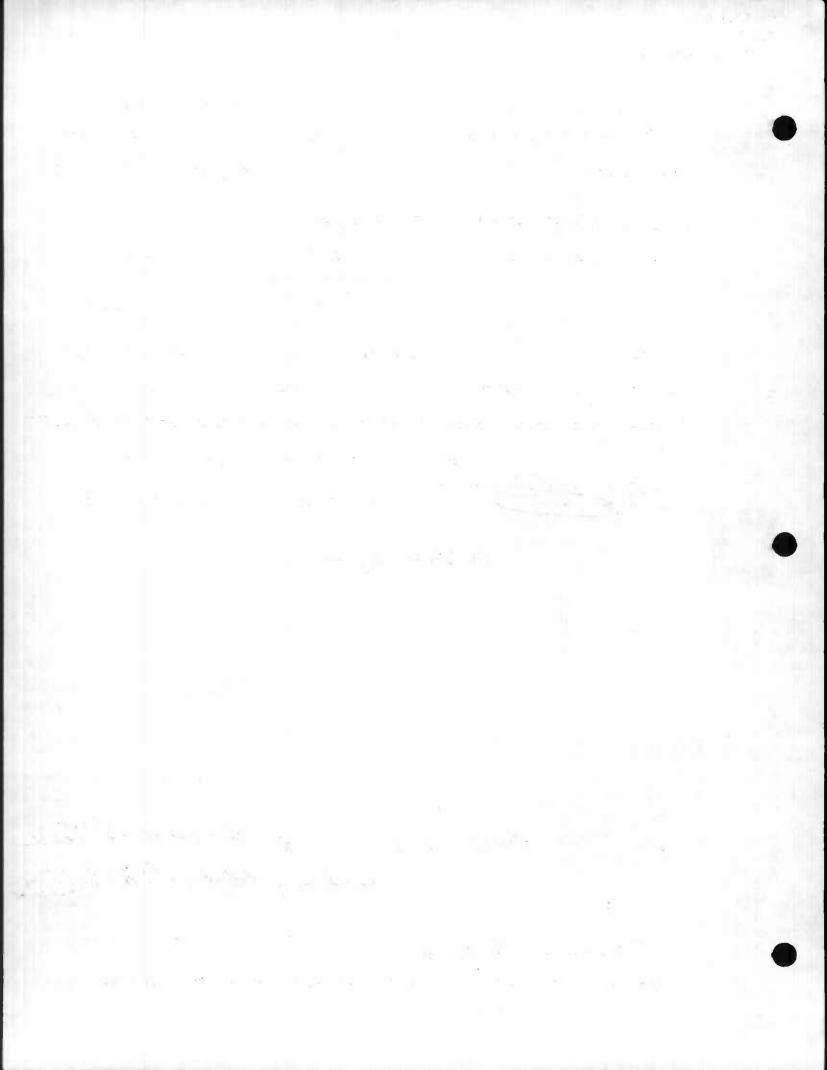
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31. Date filad (Month, Day, Year)

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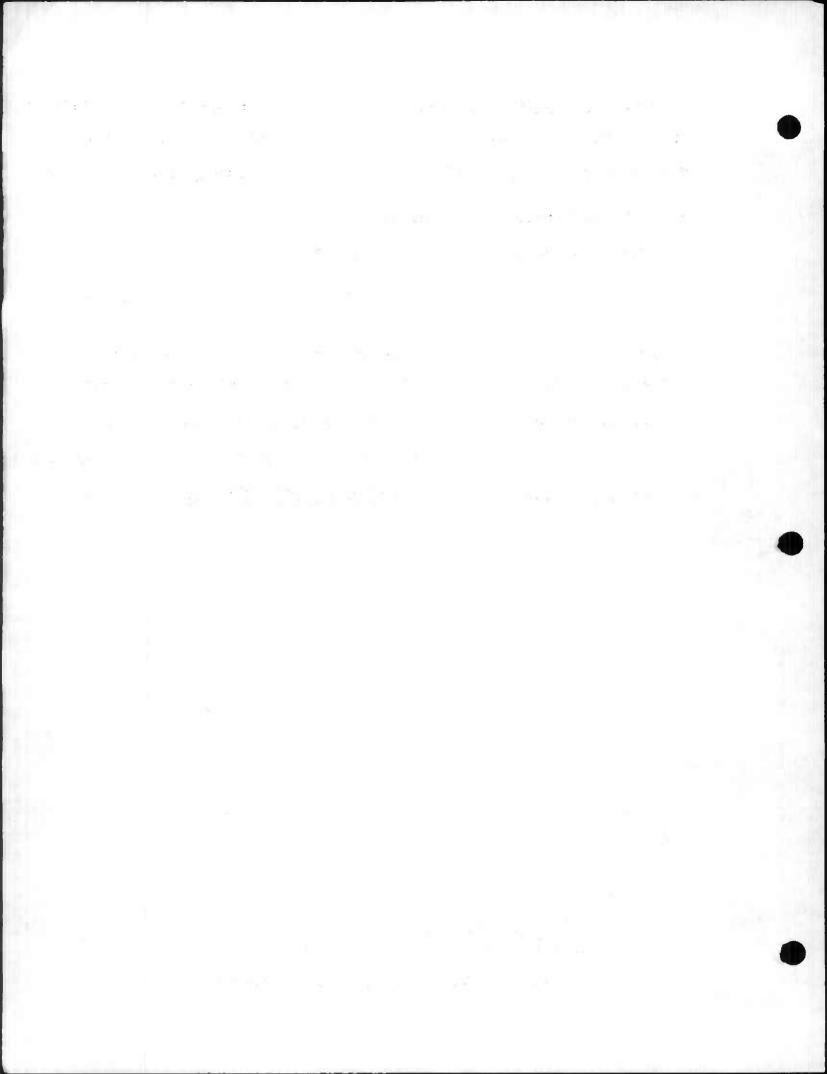
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201 porks



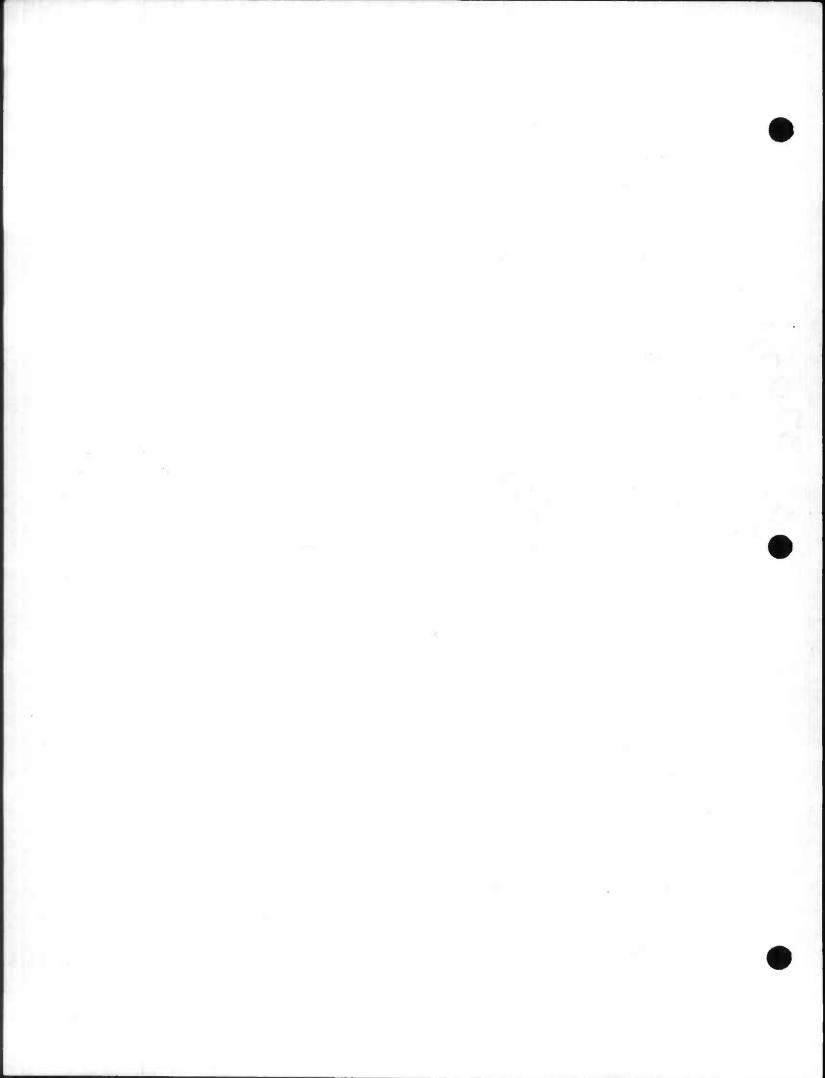
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** 1^{Day}, 1999 11:00 AM HESTER LORRAINE WILSON March /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 335 Jefferson Street Washington Hagerstown If Under 24 Hrs. Hours Min. Hours Min. February 10, 1917 5. Sociel Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F Deys Yrs. 214-09-9523 82 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Washington Maryland Yos 2 No Director Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 335 Jefferson Street 21740 items 23a U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. should be filed within 72 hours after ond Mentel Hygiene.
marked other than "natural", or iter 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mentel Hy Important: if item 27 is marked oth eny injury or other traumatic event 20cs. 18. Mother's Name (First, Middle, Maiden Surname) Samuel Franklin Forsyth Emma Elizabeth Shepley 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Jerry H. Wilson 339 Jefferson Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removal from State Rose Hill Cemtery 03-16-99 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Andrew K. Coffman Funeral Home, 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Sudden Coronary Artery Disease with occlusion disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician end s the burial-transit thet the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) 68760 Physician/Medicai Due to (or es e consequence of) Box P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown signe. Records, by The law requires 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? pege 2 certificate 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours effer death. Prunerel Director: After this certifice stely filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitai within 24 hours of To the Funerel C completely filled cal 29a. Certifier 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner steted. 29b. Signeture end litle of certifis 29c. License number 29d. Date signed (Month, Day, Year) March 12, 1999 D11266 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Howard N. Weeks, MD 580 Northern Avenue, Hagerstown, Md. 21742 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State MAR Registrar



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician,	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cardificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFIC			ENTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last) Gloria		LFORD			2. DATE OF OEATH DATE OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OEATH DATE OF OEATH DATE OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OF OEATH DATE OEATH DATE OF OEATH DATE OEAT	"2, 19"9	3. TIME OF DEATH 9:00 p.m			
	4. SOCIAL SECURITY NUMBER 213-18-9925	1 M 2 K F	77 YRS. MO	UNDER 1 YEAR	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) August 9,1	C	IRTHPLACE (State or Foreign ountry) ryland			
TOR	Mount Tabor Road RESIDENCE OF DECEDENT		- 1	Hagers	R LOCATION OF DEAT	тн	9c. COUNTY C Washi	of DEATH Ington			
DIRECTOR	10e. STATE 10b. COUNTY	ington		own on Locat			10d. INSIDE CITY LIMITS? 1 □ YES 2X□NO				
FUNERAL	16244 Mount Tal	bor Road		101	21740		109. CITIZEN OF WHAT COUNTRY? U.S.A.				
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 2 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 ANO	if yes, spe	ENDENT OF HISPANIC ocity Cuban, Mexican, 2 NO Specify:	ORIGIN? (Specify Yes Puarto Rican, etc.)	E	RACE — American Indian, Black, White, etc. Specify: white			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 0 - 7	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S USI (Give kind of work life. Do NOT use re homemak	done during mo tired.)	N St of working	166. KIND OF BUS		st.			
BE COM	17. FATHER'S NAME (First, Middle, Last) Frank A.	Mullenix		-	18. MOTHER'S NAM	E (First, Middle, Meiden Mary Dela					
TO B	196. INFORMANT'S NAME (Type/Print) Mrs. Mary Llewel	lyn/daughter	19b. MAJLING AD 11018 I			yland 21740					
	20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Specify)	oval from State	PLACE AND DATE OF C elery, chernelory, on other OADIOTOIN	g Memo	rial Gardens	Feb 1999		own, Maryland			
	21. SIGNATURE OF ELIMENTAL SERVICE LIC	MINN	in a		ast Wilso	PLLITTE		ral Home town, Maryland			
	23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition reaulting in death)	a. Poul OR AS A	CONSEQUENCE OF):	ue_		~		Approximate interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Dasheful Chronic rend unsufficiency Due to (or as a consequence of): Due to (or as a consequence of): Rhubury Turn i Hypopitusanon.										
	reaulting in death) LAST	o. Phutan			<u> </u>		- 0				
MEDICAL	PART II. Other algolificant condition					24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAIN						
rsic	1 YES 2 NO	HOSPITAL:		THER:	e 5 🗆 Rasidence	Other (Specify)	HOSPI	CE CARCE			
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	y wo	URY AT PK? /ES 2 ND	28d. DESCRIBE HOW I	NJURY OCCURE	D			
_	3 Suicide 8 Could not be 4 Homicide datermined	28a. PLACE OF INJURY building, atc. (Spec	— At home, term, atre	et, factory, offic		28t, LOCATION (Street City or Town, State)		ural Route Number,			
COMPLETED	net)	ICIAN: To the best of my knowl ER: On the bests of examination						use(s) and manner as stated.			
TO BE C	29L SIGNATURE AND TITLE OF CENTURE	auler	M	2	DIII 3	Z Z	29d. DATE SIG	INED (Month, Day, Year)			
۲	30. Frame and address or periods we	Speace	r 11110	Medica	1 Com Du	s RA Ha	was Co	ion MP2142			
	31. DATE FILED (Month, Day, Year)	32. REGITRAR'S SIGNA	ATURE	fra s	/						



Please Type or Print in Biack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** March 12, 1999 WILSON **JAMES** HENRY 8:30 am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Pocomoke City 118 Eighth Street Worcester If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) August 22, 1920 9. Birthplece (Stete or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 120 M 2□ F 78 Director 212-03-1391 Usuel Residence of Decadent the Marylend show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or thems 23a or 28a-f shot traumatic event, the Mourcel Examiner must be notified at 1X Yes 2 □ No Pocomoke City Director Maryland Worcester 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 118 Eighth Street 21851 USA pemit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health end Mental Hygiere. Important: If item 27 is marked other than "naturel", or iteme 23a eny Injury or other traumatic event, the Medical Examiner nast once. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 1 Yes 2 No If Yes, Give Yeer or Detes: Navy 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ White 3 ⊠ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 10 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) James Stokely Wilson Marie Catherine Lang 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 118 Eighth St., Pocomoke City, MD 21851 Carol Curran/Daughter altimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removel from State 3/15/99 Pocomoke City, MD Bethany Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Feneral Servica Licensee Holloway-Melson Funeral Home Dean M01129 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately the mode of dying, such as cardiac or respiratory errest, Approximately the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) do years Examiner Due to (or es e consequence of): Examiner attending physicien end for use as the buriel-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): the daath certificete be axec Box 68760. Physician/Medical Due to (or as e consequence of) 88 23b. Did tobacco use contribute to the cause of death? P.0 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Yes 2 No 3 Probably 4 Unknown ncer Division of Vital Records, by 8 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed has 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 5 Pesidence 6 Other (Specify) this 28e. Dete of Injury (Month, Dey Yeer) funeral 27. Manne of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attenditivithin 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Descritifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted. edical completely 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dey, Yeer) 29b. Signature and title of cartifier 23e) (Type, Print) d eddress of person who completed

DHMH 16 Rev 6/95

State Registrar 6

31. Dete filed (Month, Dey, Year)

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32. Registrer's 🎉

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** MARGARET LC
4a Facility Name (If not institution, give street and number) APRIL 1999 7:45 AM /Medical Ac. County of Death 4b. City, Town, or Location of Death Examiner St. Elizabeth's Nursing Home Baltimore N/A If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 03/07/1920 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 10 M 200 Hours 212-09-4617 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MD Baltimore Arbutus 1 ☐ Yes 2 No Director 10f. Zip Code 21227 10g. Citizen of Whet Country?
United States 10e. Street and Numbe b 1036 Circle Dr. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedenf Ever in U,S. Armed Forces? 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Merried "natural", or 1 Yes 2k No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Reweaver Textile 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be and Mental is is marked of Pages 1 and 2 should be Maurice Palmer Ada Parrish 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) mportant: If Item 27 is Irvin H. Ashby/husband 1036 Circle Dr. Arbutus, Maryland 21227 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 8 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4/6/99 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Ellicott City , MD 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) EREBROUASCULAR 10 MINUTES Examiner Due to (or es e consequence of) Examiner TASTASES physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. ON-SMA! Cell Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No METASTATIC Records. 2 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After complately filled in by the fune. 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. Medical 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) ATTENDING 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) MAIREN Chace LA. 720-C M ACH KRAN

State Registrar 31. Date filed (Month, Day, Yaar)

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32. Registrar's Signeture

Market Market

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey Katheryn Clara Allers 2, 1999 April 10:05AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage Meridan Eldercare Ctr. Dundalk Baltimore Co. If Under 1 Yeer 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Days Hours 218-14-4611 1 M 2 F Dec. 30,1913 Maryland Usuel Residence of Decadent 10d. inside City Limits 10e. Stete 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21221 United States 1 Brett Court Apt. 216 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Status Black, White, etc. 1X Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 Years Seamstress Retail Sales 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Catherine Lindenstruth Casper May 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1954 Dineen Drive Dundalk, Maryland Florine W. Lovell/Niece 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2☐Cremetion 3 ☐ Removel from State Hilltop Service Corp. 4/5/99 Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Towson. 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility phring L. Chos Duda-Ruck Funeral Home of Dundalk, Inc. 23e. Part (5hter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21222 Approximete interval Between Onset end Deeth CONGESTIVE HEART Due to (or es e consequenca of): Immediate Cause (Final diseese or condition resulting in death) PHEUMONIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest YULMONARY DISEASE OBSTRUCTIVE MRONIC Due to (or as a consequence of MALNUTRITION 23b. Did tobacco uea contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Was en eutopsy parformed? 211h 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 □ 16 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Deeth 28e. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel injury 5 Pending 2 No investigetion 2 Accident

physicien and the buriel-transit Division of Vital Records, P.O. Box 68760 signed by the a peeu has certificata director funeral

Examiner Physician/Medical þ Completed or Attending Physicien: after deeth. Director: After this certifica Be Certification: To Hospital
 24 hours a
 Funeral D

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryler Department of Haalth end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23s or 28s-f show any Injury or other traumatic event, the Madical Examinar must be notified as

Physician

/Medical

Examiner

Maryland 21215-0020

Baltimore,

State Registrar

completaly To the Vithin 2

Medical

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) While 2 Martiel 32 Registrer's Signeture 31. Dete filed (Month, Day, Yeer) APR 0 5 1999

1 well

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture end title of certifier

muler

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death 19_{AM} **Physician** Month APRIL OWHAW /Medical 4e. Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of De Examiner 705 Salt1 If Under 24 Hrs. an rnore 5. Social Security Number 212-22-4308 6. Sex 9./Birthplace (State or Foreign **Funeral** Days 1□M 2 F Hours Yrs Director ira Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylend nent of Health end Mentel Hygiana. 10b. County 10a. Stata 10c. City, Town or Location 10d. Inside City Limits th and Mantel Hygiana. 7 is marked other then "naturel", or frama 23e or 28a-f ehov traumstic event, the Mantral Example must be notified at Maryland
10e. Street and Number 1 XYas 2 □ No by Funeral Director more 10f. Zip Coda 10g. Citizan of What Country? 6 ira Id 0 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Rican, atc.) . Aaca - Amarican Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No 3 Widowed 4 ☐ Divorced Htto-Hmerican Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be (Nephew) 9b. Meiling Address (Street and Number or Rural Routa Number City or Town, State, Zip Code) nt of Health e 30 arriage lon 20b. Plece of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location 1 Burial 2 Cremetion 3 Removal from Stata 4 Donation 5 Othar (Specify) Depertment of Important: If any Injury or She 22, Name end Addrass of Facily JOSEPH 222 W. No. 21. Signatora of Funaral Sarvice Licanse a .21216 W. North Entar the disease, or compilications thet ceused the death. Do not entar the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying, such es cardiac or respiratory entart the mode of dying. Approximata Interval Batween Onset end Deeth **Physician** Immadiata Causa (Final disaase or condition resulting in daath) /Medical Examiner Examiner The law requires that the death certificate be executed the buriel-transit Sequantially list conditions, if eny, laading to immadiate ceusa. Enter Underlying Causa (Disaasa or Injury that Initiated evants resulting in daath) Last and Dua to (or as e consequance of) Box 68760, Physician/Medicai Dua to (or es e consequance of): 80 be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? ENSION 2 No 3 Probably 4 Unknown Records, Completed by 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Wes an autopsy page 2 certificate 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: the funeral director, 25. Was cese refarred to medical axaminer? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yes 1 Inpatiant 2 ER/Outpetient 3□ DOA this 27. Mannar of Beeth 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 2 Accidant 5 Panding Investigation 1 TYas 2 TNo 24 hours after deet Puneral Director: 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) completely filled in by 4 Homicida Hospital Medical 29a, Cartifier To tha best of my knowladga, daath occurred et tha tima, data and place, and due to tha causa(s) and manner es stated. On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. Licansa number

State Registrar

31. Data filad (Month, Day, Year)

5 1999

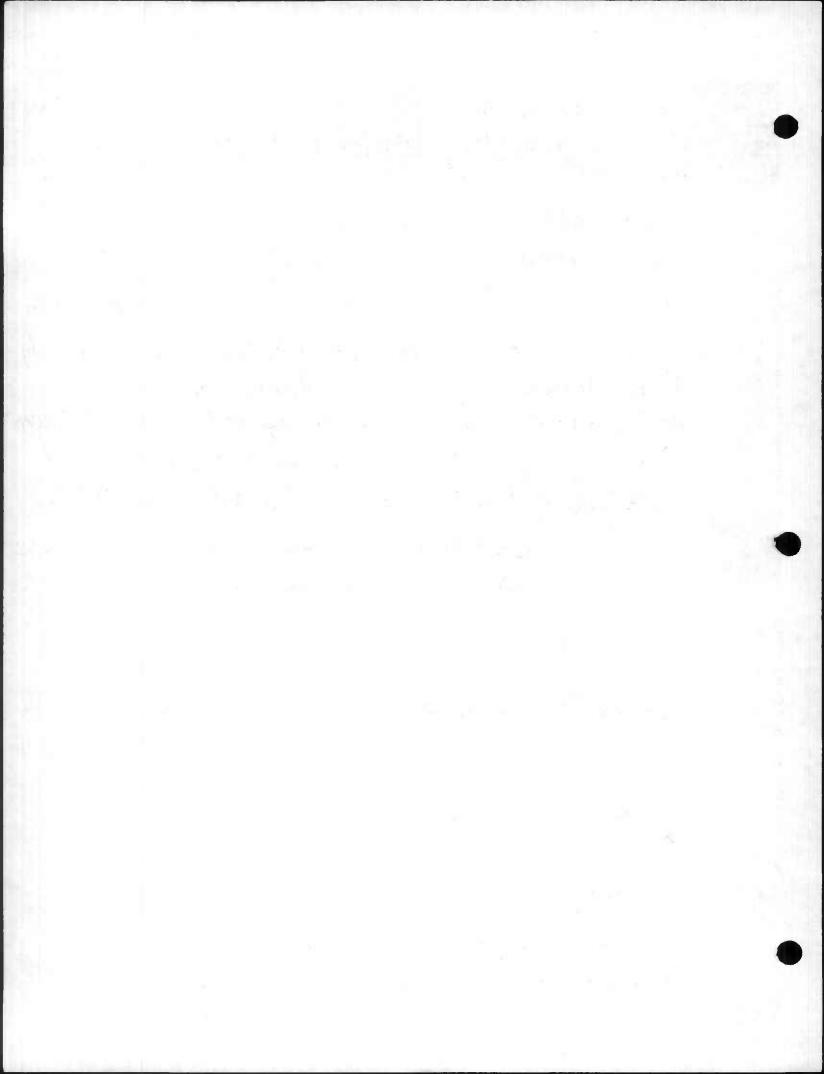
32. Registrar's Signatura 12 partindo

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ime and andrass of person who complated cause of death (Item 23e) (Type, Print)

RD

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:25 a.m. **Physician** Year Lueater Barnett March 30, 1999 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore n/aIf Undar 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 M 2 K Yrs 073-16-6362 90 Director Jan. 12, 1909 S.C Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Md. n/a Baltimore Director 1DOYS 2 □ No 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 8 1100 Bolton Street Apt. 612 21201 Nerns 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or he any Injury or other traumatic event, trained Exemples place. 1 Nevar Marriad 2 Married 1 Yas 2 No H Yes, Give Year or Datas: Saltimore, Maryland 21215-0020 1 Yes 2 to Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Factory 6th Grade Seamstress 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ellie Durant Evalina McPherson 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) niece Geraldine James 1605 Winford Road Baltimore, Md. 21239 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State April 5 Baltimore, mo. Zion ('emetery 4 ☐ Dogatton 5 ☐ Other (Specify) re of Funeral Solvice Licensee 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Between Onsel and Death **Physician** /Medical Immediate Causa (Final disaase or condition resulting in death) Examiner Examiner morro Selenton law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) physician s the buria Box 68760, Physician/Medicai Due to (or es e consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 4 Hospital or Attending Physician: 24 hours after death. 5 Funeral Director: After this certifical etely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Ho 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled edical (1 Dertifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted. 29a. Certifier To the 29b. Signatura and title of certifian 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year). APR

SHOA113

32. Registiar's Signature

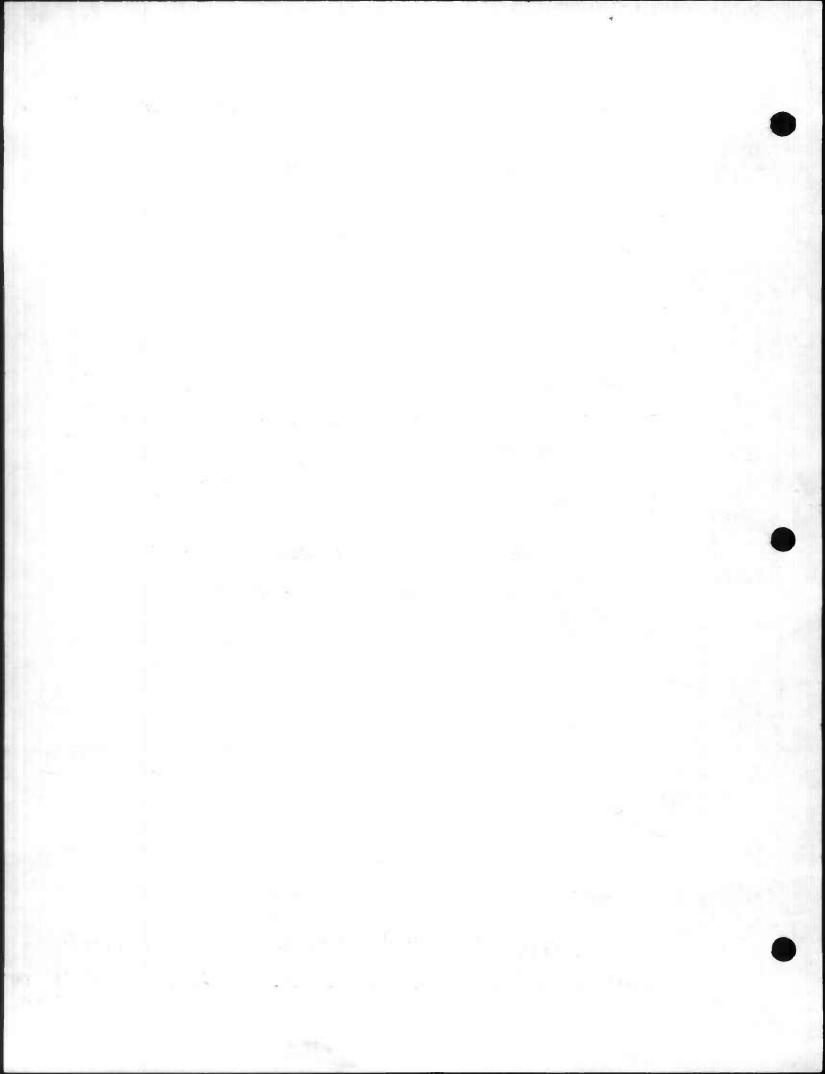
30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

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ate of Maryland / Department of Health and	Mental Hygiene	^	ting	
Certificate of Death	Reg. No.	U	-/	6
	2 Date of Dooth	T	2 7	ima al

Physicia /Medica Examine

KAMAL TAVERIUS BRANHAM

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Introcramt: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Hindred Eventual Process.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours effer death.

To the Funeral Director: Affer this certific complately filled in by the funeral director,

			Certific	ale or	Deau		Reg. No.		7 1 0 7
Decedent's Name (First, Middle, L Kamal Taverius B:						2. Date of Month MARC	Day	Year 999	3. Time of Death 2332 PM
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Usual Rasidanca of Dacedant		140 00 7	1 2 2					1	
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Md.	n/a		Baltimo	ore					1 My Xes 2 No
10e. Street and Number 2406 East Coldspi	ring Lane		10f.	Zip Code	21214		10g. Citizen o		ry?
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21. Signature of Funeral Senice Lice	ce to	taters			ss of Facility S Fall	Nutter s PKWY B	Funeral altimore		
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that initiated evants resulting in death) Last	d	Due to (or es e	consequence	of):				t	
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examiner? ₹XYas 2 No	Hospital:	patient 2 KiX-pir	Outpatient 3	DOA OU	NOT:	sing Home 5 🗆 I		Other (Soncill	1)
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2 Accident Invastigation 3 Suicide 6 Could not 1 4 Homicida datarmined	28a. Placa o	f Injury - At homa, b, etc. (Specify)	farm, street, fac	ctory, office		28f. Locati	on (Street and Nu	mber or Rura	Play Ave
	hysician: To the bominer: On the base and manne	is of axamination a	ge, death occur	red at the ti					
29b. Signeture and little of certifiar	and mainto		-	29c. Licens	se number		29d. Date sig	ned (Month, I	Day, Year)

State Registrar 29b. Signeture and little of certifian

30. Nama and address of person who o Dennis

31. Dete filed (Month, Day, Year) A

DHMH 16 Rev 6/95

pplated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

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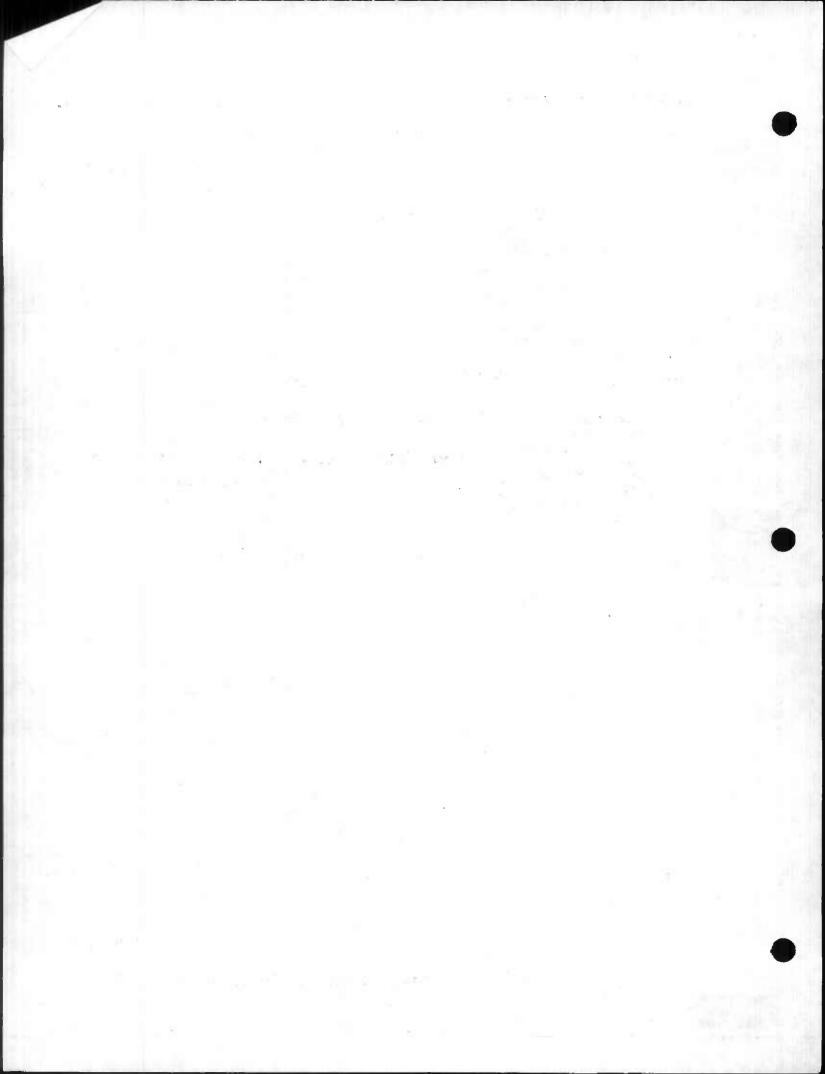
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29c. License number

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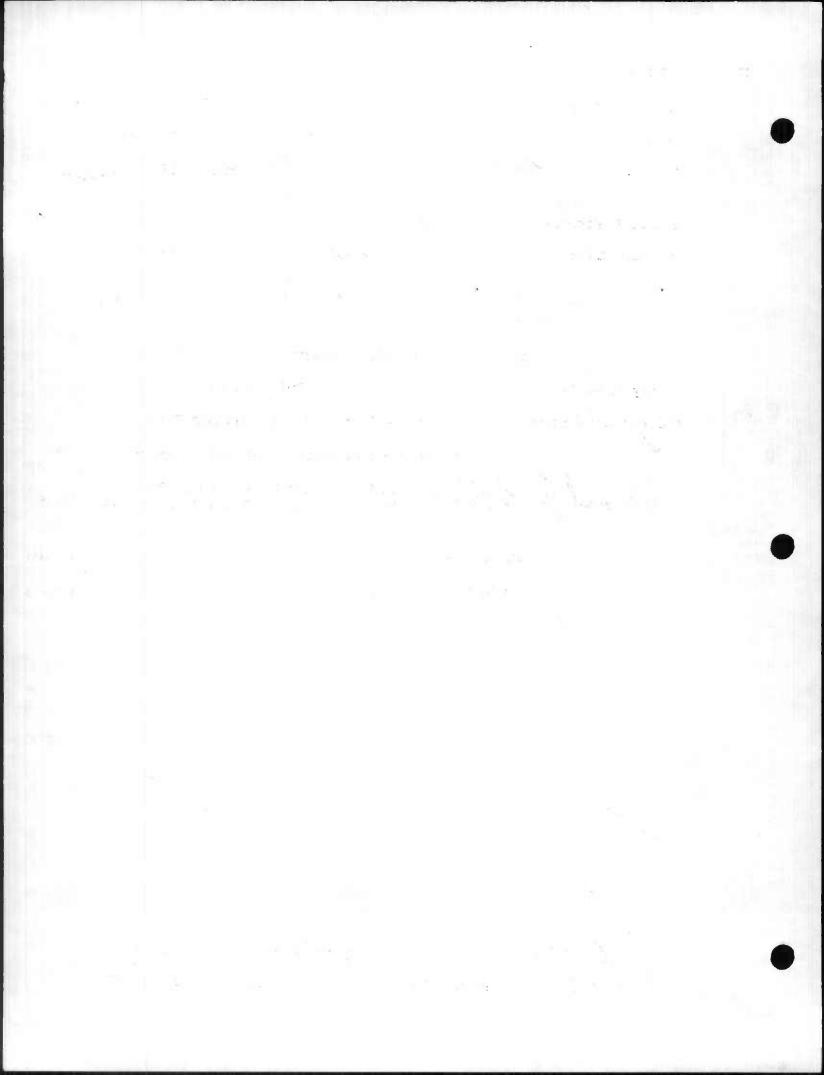
111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) MARCH 30, 1999



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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate	of	Death			Reg. No.				
1. Decedent's Neme (First, Midd						2. Date of De Month		3. Time of Deat					
Leona Barne	tt								Day 24 1	999	3.10.21		
4e Facility Neme (If not institution	on, give street end num	ber)				4b. City, To	own, or Lo	ocation of Deat		ty of Death			
Lavendale Geri	atric Nurs	ing Home				Ba1t	imor			timor	e		
5. Sociel Security Number 111-07-0275	birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De Dec. 1	th ay, Year) .0, 1916	9. Birth	place (State or Fore intry) known				
Usuel Residenca of Decedent													
10a. Stete 10b. Count		10c. City, To							10d. Inside City Li				
Maryland Balt	imore City	Balti	more	2					1 € Yes 2 □				
10e. Street end Number 2434 W. Belve	edere Avenı	ıe ′		10f. Zip C					10g. Citizen of What Country? U.S.A.				
11. Maritel Stetus	12 Was Decer	dent Ever in U.S. ces? unknow	13.	Was Deceder	nt of I-	lispanic Or	No- 14. Race - American Indian,						
1 ☑ Never Merried 2 ☐ Me 3 ☐ Widowed 4 ☐ Divorce		If Yes, specify 1 ☐ Yes 2 €		Specify:		Hican, etc.)		ack, White ity: Wh:					
15. Deceder (Specify only higher	Sa. Dece	dent's Usual (Occup	pation during mos	st of work	ina	16b. Kind of I	Business/Ir	ndustry				
Elementery/Secondery (0-12)		kind of work DO NOT use	retire	d)									
Unknown	Unk	cnown		40.04.10	- I- Ni	- 457-14 A 67-14	Unknow						
17. Fether's Neme (First, Middle							, Maiden Suma	me)					
Unknown							know						
19e. Informent's Neme/Reletion Vivian Shub/ce		1							er, City or Town				
	Justii	001 51				gton .	aven				land21207		
20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (4		tete ceme	tery, cre	osition (Name metory or oth	er ple	ce)	1	Date	20c. Location	- City or T	own, State		
21. Signature of Funeral Service Joseph	Licensee		22	Name end	Addre	ss of Fecili	ity Boar	d, 655	W. Balt	imore	e Street		
23a. Part1. Biller the diseese, o	O. fan	Alm)						d 21201					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events	b	e consequence of): e consequence of):							1				
resulting in death) Last	d		r consequence or;										
Pert II. Other significant conditi	ons contributing to dea	th but not resulting	g in the u	nderlying cau	use giv	ven in Pert	l.	23b. Did	tobacco use c	ontribute	to the cause of de		
SENILE DEM	ENTIA ME	WIAL RE	TARI	AFID~			10	23b. Did tobacco use contribute to the cause of de					
NON INSULU	1 DEPEND	ENT DIA						24a. Wes	24a. Wes an autopsy performed?		b. Were eutopsy finding available prior to completion of cause of death?		
,								10	Yes 2000	1	☐Yes 2☐No		
25. Wes case referred to medica	al _					26. Place	e of Deet	h (Check only	/ \				
examiner? 1 Yes 2 No	Hospitel: 1 □ In	patient 2 ER/	Outpatier	nt 3 DOA	Ott	or .			dence 6 🗆 O	ther (Snec	ifu)		
27. Menner of Death 1 Naturel 5 ☐ Pendi	28a. Dete of (Month		o. Time of Injury		. Inju				how injury occu		,/		
3 Suicide 6 □ Could								28f. Location (City or To		nber or Rui	ral Route Number,		
29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the basend menne	is of examinetion	lge, death and/or in	n occurred et vestigation, in	the tin	me, date er opinion, dea	nd place, ath occurr	and due to the red et the time,	d due to the cause(s) end menner es stated. et the time, date end place, and due to the cause(s)				
29b. Signeture end title of certific	or Δ.	TTENDIM	29c. License number					29d. Date signed (Month, Day, Year)			, Day, Year)		
(6)	Ey Ew PHYSICIAN						0		MARCH. 24- 1999				
30. Neme end address of person	(war	4751C1HA		Eleint\					· mc	7. 24.	- 1777		
SET HTWAR MIT					ERI	ERE	AVE	ENUE B	ALTMOR	E MI)	21215.		
31. Dete filed (Month, Dey, Year,	32. Re	gistrer's Signeture							- 1				
APR 0 5 199	y sens	a 19			4								

DHMH 16 Rev 6/95

Registrar

Phys /Me Exa

Fune Direct

Baltimore, Maryland 21215-0020

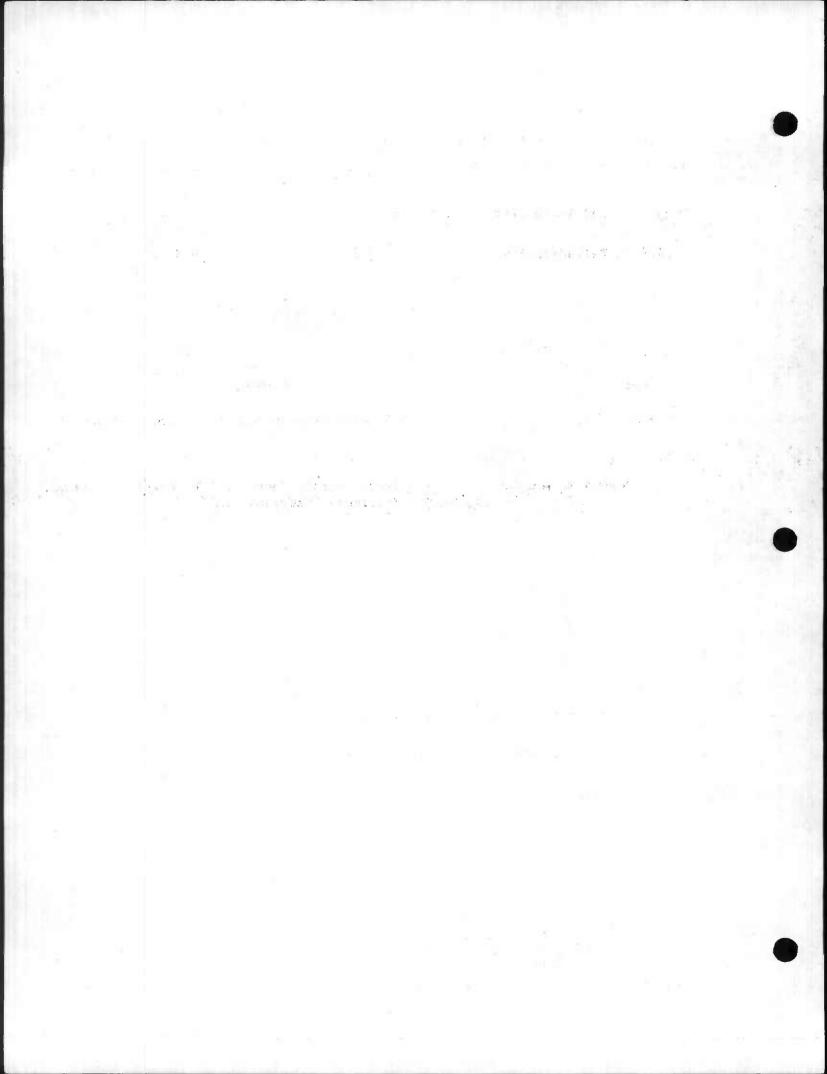
Physicia /Medic Examin

To the Mosphal or Attending Physicien: The law requires that the death certificate be assivithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician a

Division of Vital Records, P.O. Box 68760,

LEONA



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth **Physician** APRIL 04 1999 ALICE CATHERINE COX 3:53 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 8436 ALVIN ROAD PASADENA ANNE ARUNDEL CO. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 04 1934 7. Age (In yrs. last birthday) **Funeral** 9. Birthplece (Stete or Foreign 215-30-4089 1 □ M 2 💢 F Months Days Hours Min 64 Yrs. Maryland Director Usuel Residance of Decedent the Marylend 10a, Stete 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** Md. Anne Arundel Co. Pasadena 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Counfry? ō filed within 72 hours efter death with 8436 Alvin Road 21122 **USA** itema 23a 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Datas: 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yes 2X No Specify: white by Specify. 3 Widowed 4 Divorced "naturel" Completed 16e. Dacedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Dacedent's Education 16b. Kind of Businass/Industry (Specify only highest grede complated) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Owner other traumatic event, Baltimore, Maryland permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If item 27 is marked other eny injury or other treumetic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Clyde Eugene Stivers Mary Agnes White 19a. Informent's Nama/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, State, Zip Code) Clint H. Cox (Husband) 8436 Alvin Road, Pasadena, Md. 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Locetion - City or Town, Stete 1 X Burial 2 Cremetion 3 Removal from Stete Meadowridge Memorial Pk.4/6/99 Elkridge, Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 21. Signatura of Funerel Service Licenses 3204 Mountain Road Pasadena, Md. 21122 23a. Part. Enter the disease, or complicefions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech lina. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceusa (Final small cold luy cance disease or condition resulting In deeth) 10 MOUTY Examiner Dua to (or es e consequance of): Examiner or Attending Physician: The law requires that the death certificate be executed effor death. Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In deeth) Lesf Due to (or as e consequence of) Box 68760, physician Physician/Medical Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t TEYes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to complation of ceuse of deeth? Completed 24a. Wes en eutopsy peeu performed? page 2 1 Yas 2 No certificete 1 Yas € No Be 25. Was cese rafarrad to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatiant 3 DOA Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yas 20 No this funeral 27. Mennar of Deeth Certification: 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred After Naturel 5 Pending 2 Accident investigation 1 Yes 2 No within 24 hours efter death To the Funeral Director: 3 Suicide 6 Could not be datamined 28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical 29a. Cartifian 1 Certifying Physician: To tha bast of my knowledge, daath occurrad et the time, dete end place, and due to the ceusa(s) and manner as steted. (Check only one) 2 Medical Exeminer: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, and dua to the ceuse(s) end manner stated. 29b. Signeture and title of certifier 29c. License number 29d, Defe signed (Month, Dev. Year) win 30. Nama and eddrass of person who complated cause of death (Itam 23a) (Type, Print) 4940 EATTERN AVE BALTIMOTE VERIL UMPUML 31. Dete filed (Mont. Day, Year) 32. Registrar's Signeture State Registrar

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene Q

Item#23apt1B perPhyG770 4/5/99EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** James Francis Connors March 15 1999 6:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 McCann Avenue Cockeysville Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) H Under 1 Ve Birthplace (Stata or Foreign Country) **Funeral** Hours 1 M 2□ F Days Months Yrs 201-24-6750 66 Pennsylvania Director June 5 1932 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumetic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Cockeysville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 7 McCann Avenue Nerns 23a USA 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heelih and Mentel hygiene. Important: if item 27 is marked other than "natural", or the any injury or other traumatic averse. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1950 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dept. of 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Baltimore County Elemantary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic-Utilities Government 10 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be James Joseph Connors Edith VanDine 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs. James F. Connors/Wife 7 McCann Ave., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/18/99 Dulaney Valley Mem. Gardens Timonium, MD of Funeral Service Ligania 22. Name and Address of Facility 21 Signatur Bryan W. Cl Lemmon Funeral Home 10 W. Padonia Rd., Timonium, Clary If the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hourt failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical NODIA Examiner Due to (or as a consequence of) Examiner CARDIOMYOPATHY 2 Years that the death certificate be asscuted physician and the burial-tran Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but set resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown MAKE OCK signed t Records, Completed by The lew requires 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 s has 2 DNO 1 ☐ Yes 2 ☐ No 1 Tes Division of Vital Hours after death.

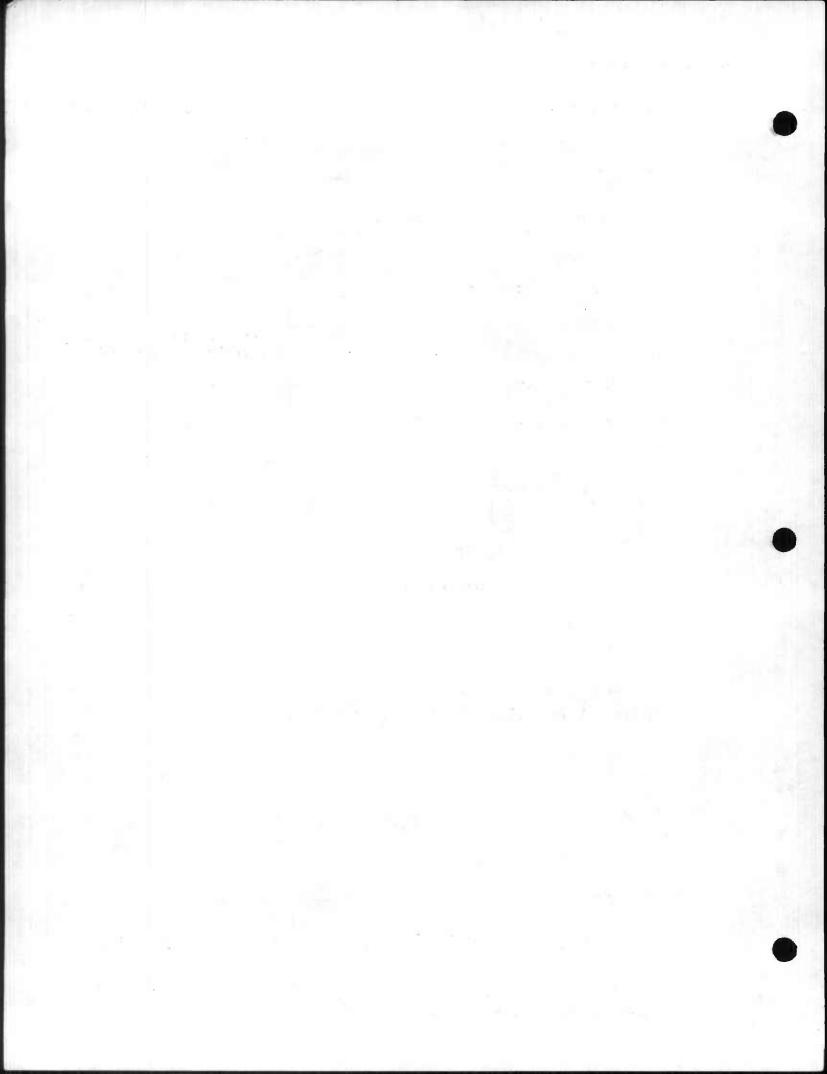
4 hours after death.

Funeral Director: After this certificate
ely filled in by the funeral director, pa 25. Was casa ratarred to medical examiner? Be 26. Place of Death (Check only ona) 1 Vas 2 No Other: 4 Nursing Home Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 27. Manper of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident invastigation 6 Could not be 3 ☐ Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the To the I 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Year) 16 ag 736231 30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) James Dicke, M.D. 6565 N. Charles St., Suite 411, Towson, MD 21204 31. Date filed (Month, Day, Year) APR 0 5 1999 2. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ELLSWORTH COATES 12:30 AV April 1999 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Burnie Hospital North Arundel Glen Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthpleca (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10XM 20 F 212-01-7883 Yrs. 01/14/1903 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner maint be notified at MD BALTIMORE 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2025 N. Fulton Avenue 21217 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Black 1 ☐ Yes 2 No Specify: py 3 ₭ Widowed 4 Divorced 'natural'. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Afro American Elementary/Secondary (0-12) College (1-4or 5+) Presser 12th Newspaper permit. Pages 1 and 2 should be file. Department of Heelth and Mental Hyg important: If frem 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Joseph Coates Sarah Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joann Jennings 7740 Monaghan Road, Glen Burnie, MD 21061 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park4-7-99 Arbutus, Maryland 4 Donation 5 DOther (Specify) Willie & SON E. Howell, Jr FUNERAL HOME, 22. Name and Address of Facility LEROY O. DYETT SON 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 5 Rock Examiner Due to (or as e consequenca of): Examiner e por sa consequenca of): physician and the burief-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or as a consequenca of): 98 USB (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1□ Yes 2 No 1 ☐ Yes 20 No ollure 25. Was ease referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15000 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print) #8 Glen Burnie Md. 21061 Do-Hsiu 1916 Crain HWY, SW

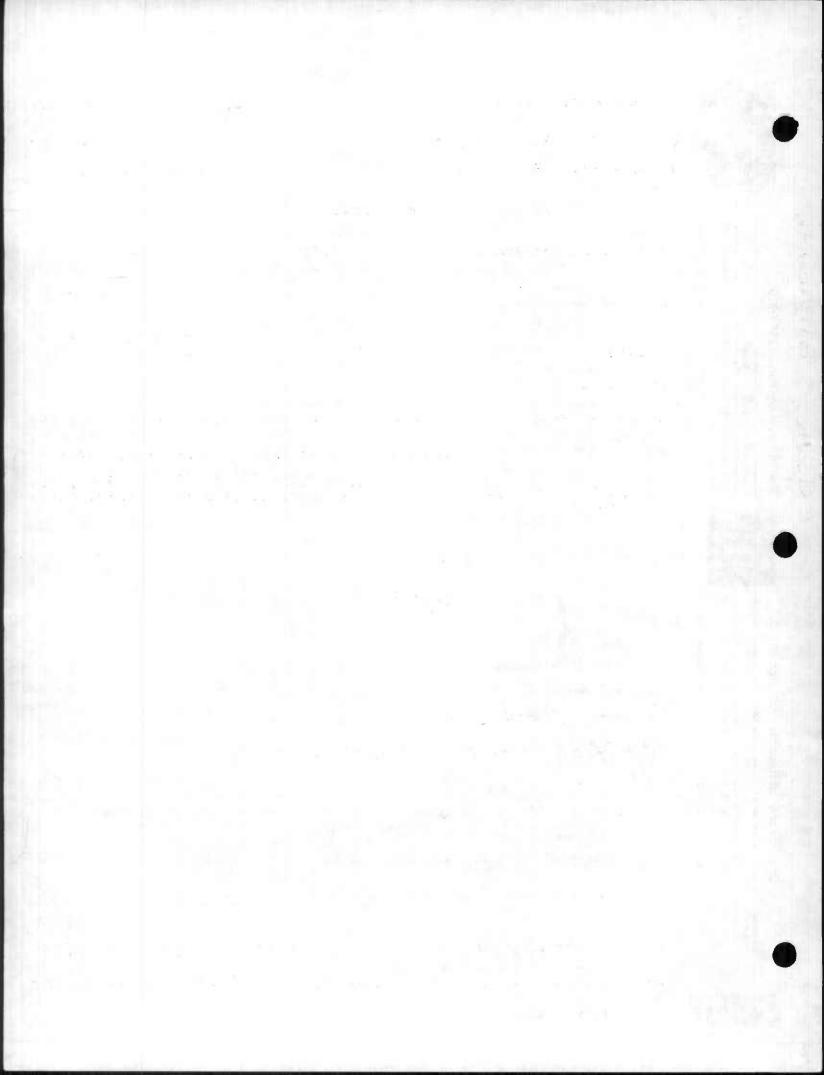
32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

115 corth

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physiclan** S AMonth 1055AM Warren Davis 1999 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tranktord Medical Specialty Unit Baltimore n/a If Undar 1 Yaar 5. Social Security Numbar If Undar 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dale of Birth (Month, Dey, Year) Feb. 6, 19 Birthplace (Stete or Foraign Country) New York 63 Months Days Hours 081 26 0827 6, Usual Rasidance of Decadent 10a. Slate 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Maryland n/a Director NOXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5409 Summerfield Ave. 21206 United States Funeral 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Marriad 1 Yes 2 No 1 ☐ Yes 2 No Specify: Black. by 3 Widowed 4 Divorced Year or Dales Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Heating and Air Conditioning 15. Decedent's Education (Specify only highast grede completed) 16b Kind of Business/Industry Residencial and Elementery/Secondary (0-12) College (1-4or 5+) Commercial Installatn. 12 Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Charles Davis Anna Coleman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Louis C. Davis, Sr., Son 5409 Summerfield Ave., Baltimore, MD 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from Slate Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/6/99 Baltimore, MD 22. Nama and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death 40 Cardial immediete Cause (Finel disease or condition resulting In death) Examiner nvonavy Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Last Physician/Medical Dua to (or as a consequence of): Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 97 1 Yss 2 No 3 Probably 4 Unknown is ease ò Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Certification: To Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Sulcide 6 Could not be determined Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) Localion (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be axecuted pue Division of Vital Records, P.O. Box 68760. ettending physicien signed by the et or Attending Physician: this Affer t death. within 24 hours efter death.

To the Funeral Diractor: A completely filled in by the fi

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Medical Examiner man be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiona. Important: If item 27 is marked other than "natural", or hanny injury or other traumatin.

Physician

/Medical

Examiner

Maryland 21215-0020

altimore,

with the Maryland

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signatura and title of certiflar

APR

29c. Licansa number D0052940 29d. Date signed (Month, Dey, Yeer)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)
SANTAY P. SHAH, MD 10605 HICKON

SHAHIND 10605 Hickory Lidge Rd #210, Columbia, MD 21044

State Registrar

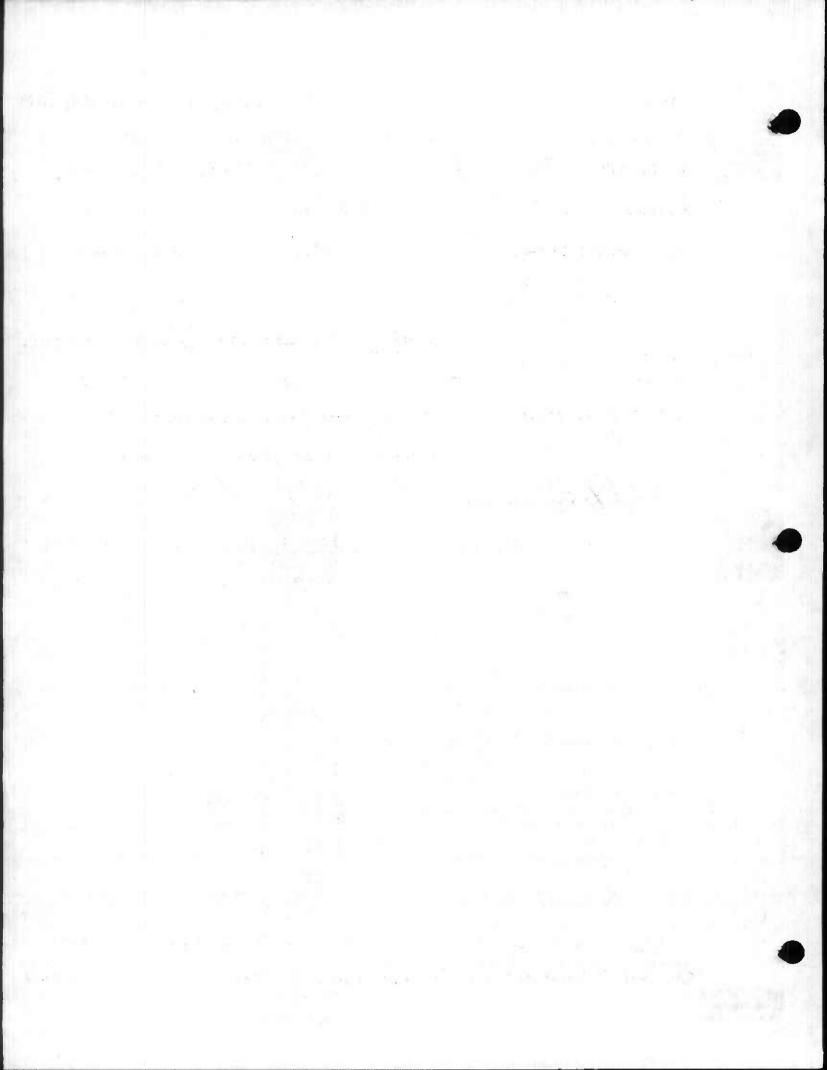
Medical

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

5 1999

To the Hospital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year **Physician** APRIL **EDNA** M. DURANT 5:15 AM 1999 4, /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 8. Data of Birth (Month, Day, Year) July 31, 1934 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 10M 20F Months Hours 219 26 9888 64 Virginia Director Usual Rasidanca of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic avant, for Macical Examinar must be notified at Baltimore Baltimore Maryland Director 1 ☐ Yas 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6800 Liberty Rd. 21207 Apt.310 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or feer any Injury or other traumatic avant 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) L.P. Nurse Medical / Hospital 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Edgar Brown Annie Marie Chambliss 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Annie R. Collins / Sister 14524 Good Hope Rd., Silver Spring, MD 20905 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4/5/99 Green Mount Crematory Baltimore, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. ohun 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Ental the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in daath) 6 monly Examiner Examiner physicien and s the buriel-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Box 68760 the death certificate be Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Munknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. tnjury at Work? 28d. Describe how injury occurred After ! To the Hospital or Attanding I within 24 hours after deeth.
To the Funeral Director: After 1 Natural 2 Accidant 5 Panding Invastigation 1 Yes 2 No 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number () lane 30. Nama and addrass of person who complated causa of death (ftem 23a) (Type, Print) N. Eutaw St. #308 Balto. Md. 21201 Sabarathi 821 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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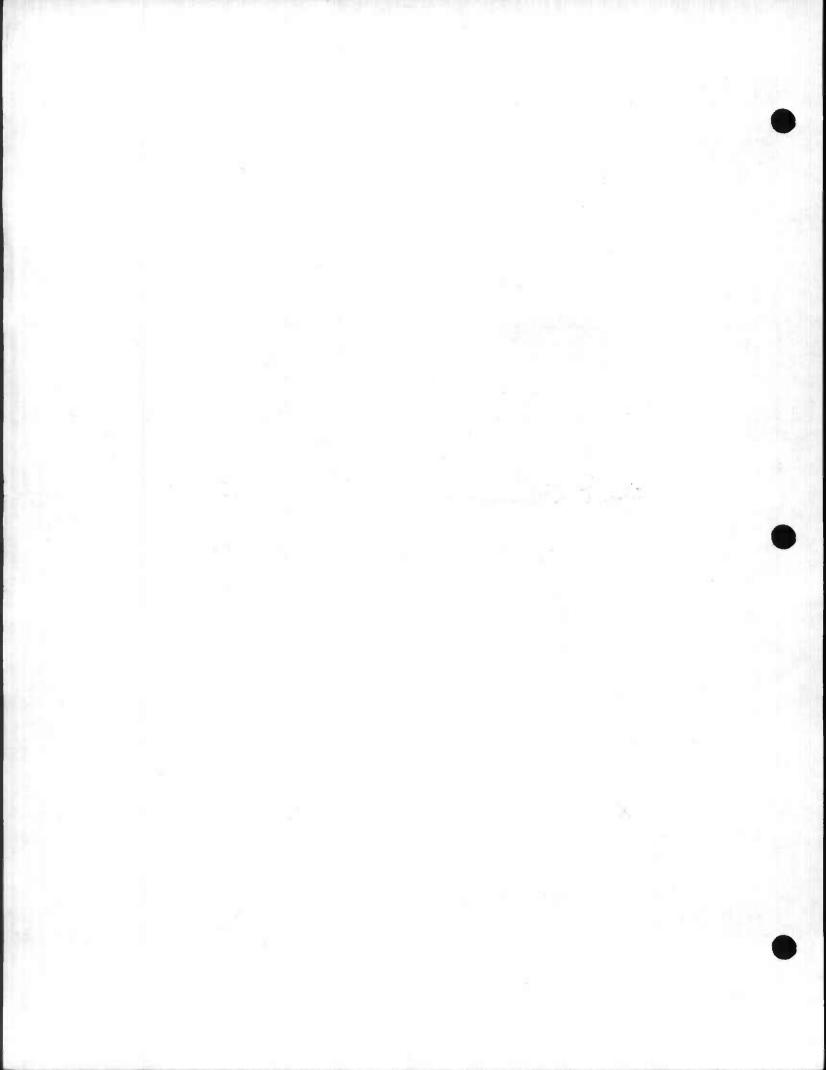
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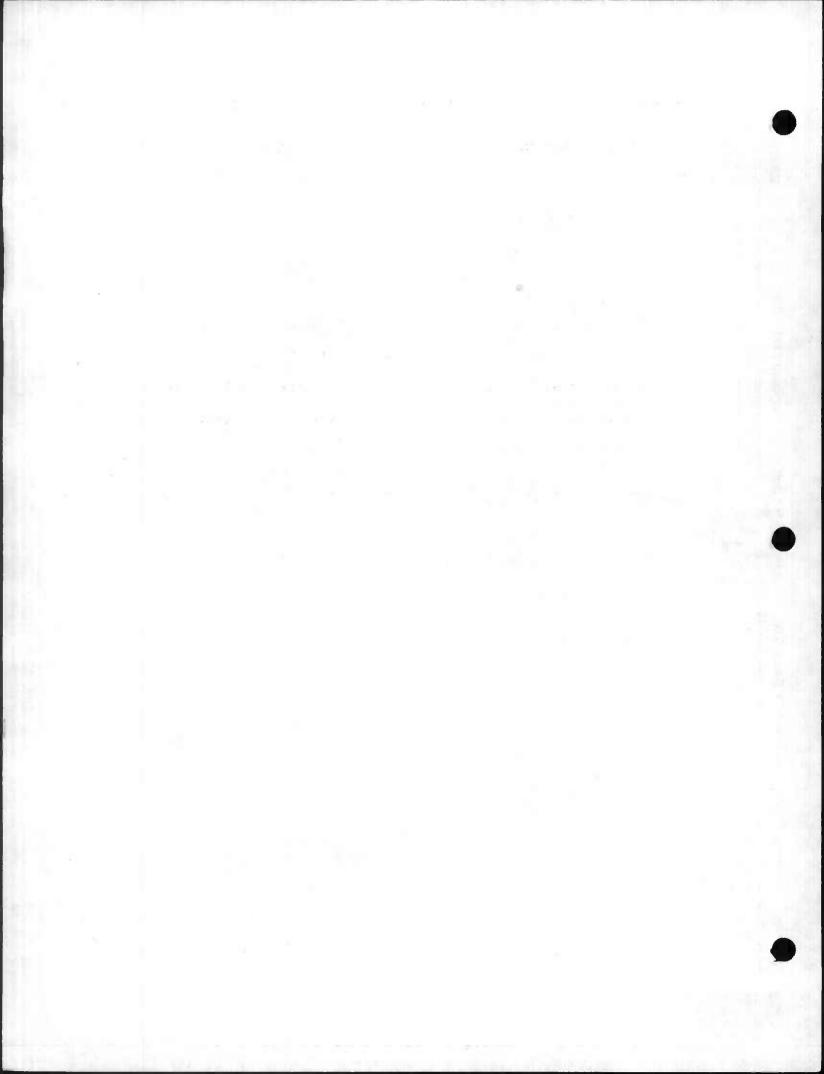
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 9:00 AM THEODORE DYMICKI APRIL 2, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 756 Old Stevenson road Severn
If Under 24 Hrs. Anne Arundel If Under 1 Year Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1₩ M 2□ F Yes 214-46-1048 Director 1-31-48 MD Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Directo 28a-f Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? must be r 21144 USA 756 Old Stevenson Road death Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1968-72 hours after 1 Never Married 2 Merried b 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 I Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Truckdriver shipping Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be formal H ment of Health and Mental H tant; if them 27 is marked oth lury or other traumatic even 88 Walter J. Dymicki Sr. 2 Edna (Wheeler) Dymicki 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dolores Mitchell (Sister) 1022 Fairway Ave. Glen Burnie MD 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State DBurial 2 ☐ Cremetion 3 ☐ Removal from Stata Department of Important: If any injury or ance. 4-6-99 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Enter the disease, or complications that caused the shock, or heart teilura. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Finel enoto ber disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner g physician and as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): 880 signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed paga 2 s this certificate has 1 Yas 2 No 1 Yas 2 LNo of Vitai or Attending Physician: 25. Was casa refarred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 | Yes 2 | 1 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. injury et Work? After Division 1- Netural 5 Pending investigation after death.

Director: After turn of in by the furnitudes. 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. edical 29b. Signature and file of certifier 29d. Date signed (Month, Dey, Year) 29c. License number DIPSOP 30. Name and eddrass of person who complated cause of death (Item 23a) (Type, Print) crain thuy \$100 Glen Burnie MDZIDGE harles J. WU. M.D. 1600 S 31. Date filed (Month, Day, Year) Registrar's Signeture State 0 5 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 2:10 AM ORIL Decorse **62** /999 4c. County of Death 4a. Facility Neme (If not institution, giva straet and number) 4b. City, Town, or Location of Daath Baltimore Battimore ak Crest Village. Care Center If Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Security Number Birthpleca (State or Foreign Country) 1 M 2 F Days 216-14-3320 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ☑ No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 8800 Walther Blvd. Apt 3008 21234 U. S. A. 12. Wes Dacedant Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 凝χNo If Yes, Give Yeer or Detes: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Edwin F. Johnston Bessie Wortham 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Patricia A. Kimmett (Daughter) 108 Westbury Road, Lutherville, Maryland 21093 20b. Placa of Disposition (Neme of camatery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park Cemetery 4-5-99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Ruck Towson Funeral Home, Inc. 21. Signeture of Funaral Servica Licensee 121-1050 York Road, Towson, Md. 21204 23a. Part1. Enter the disaase, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete intervel Between Onset end Deeth BRAIN STEM STROKE Immediate Causa (Final BWeeks diseese or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 XNo 26. Plece of Deeth (Check only one)

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner mant be notified at

permit. Pages 1 and 2 should be filed within 72 hours after begardnent of Heath and Mantal Hygiene. Important: If Item 27 is merked other than "natural", or iter any injury or other traumatic avant

with the Maryland

burial-transit and physician s s the bunaluse as attending signed by the atte been si cartificata

funeral

Attending Aftar

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afta completely filled in by the fun.

that the death certificate be axecu

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ò Completed Certification:

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

4 Homicide

29a. Certifier

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☐ Yes > No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred

27. Menner of Deeth 28c. Injury et Work? Natural 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at tha tima, date and placa, end due to the ceuse(s) and menner stated. 29b. Signature end title of cartifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

-GaulknermD 18800 Walther Slyd / Baltimore MD 21234 31. Date filed (Month, Day, Year)

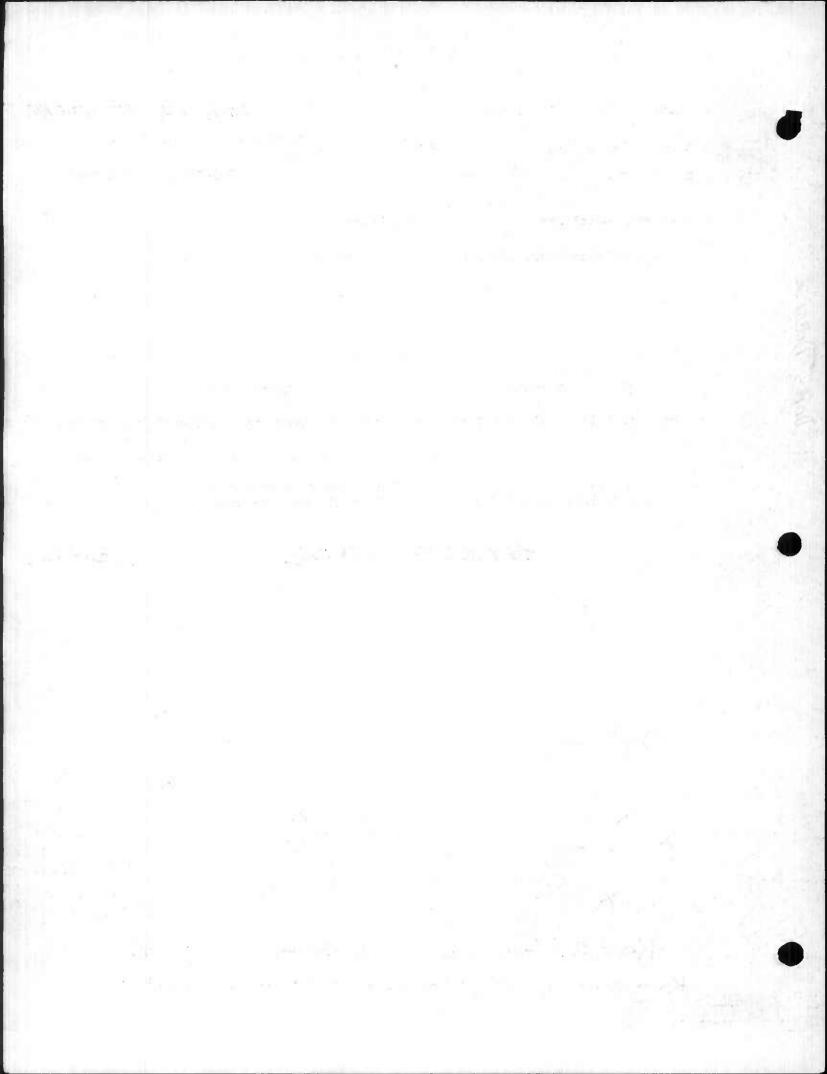
State Registrar

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32. Registrer's Signeture







Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** 12:58PM Brian E. DiMaria /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Baltimore 14 Austin Rd. Reisterstown | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | Feb. 28, 1956 5. Sociel Security Number 6. Sex 1∆ M 2 ☐ F Birthpleca (State or Foreign Country)
 NAV 7. Age (In yrs. lest birthday) **Funeral** 108-50-3499 43 NY Yrs. Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23a or 28a-f show traumstic event, the Modical Examiner must be notified at 1 Yas A No Director Baltimore Reisterstown 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 14 Austin Rd. 21136 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturst", or items 23a any Injury or other traumatic event, the Wedien Essention ma. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tile Mechanic Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Nama (First, Middla, Last) New LLE QUINK John DiMaria 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 14 Austin Rd., Reisterstown, MD Laureen H. DiMaria Wife 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 4/5/99 4 □ Donation 5 □ Other (Specify) Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136.

23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximately a such as cardiac or respiratory arrast,

Approximately a such as cardiac or respiratory arrast,

Approximately a such as cardiac or respiratory arrast,

Approximately a such as cardiac or respiratory arrast, Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Dua to (or as e consequence of) Physician/Medical Examiner 250012 attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest (or es e consequence of) Records, P.O. Box 68760, Due to (or as e consequenca of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? ed by the s signed by t 1 Yes 2 No 3 Probably 4 Junknown à 24b. Were eutopsy findings available prior to complation of causa of deeth? 24a. Was an autopsy performad? Completed Laily Eigorette peeu this certificate has 1 Tyes 2 10 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Hospitai: Other: 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Tes 2 No after death. within 24 hours after death To the Funeral Director: / completely lilled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date end place, end due to the causa(s) and mannar es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 29a. Certifier (Check only one) Medical To the Vithin 2 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of sertifier 99c. Licensa number 30. Name and eddress of person who completed cable of deeth (Item 23e) (Type, Print)

> LONNE egistrar's Signature

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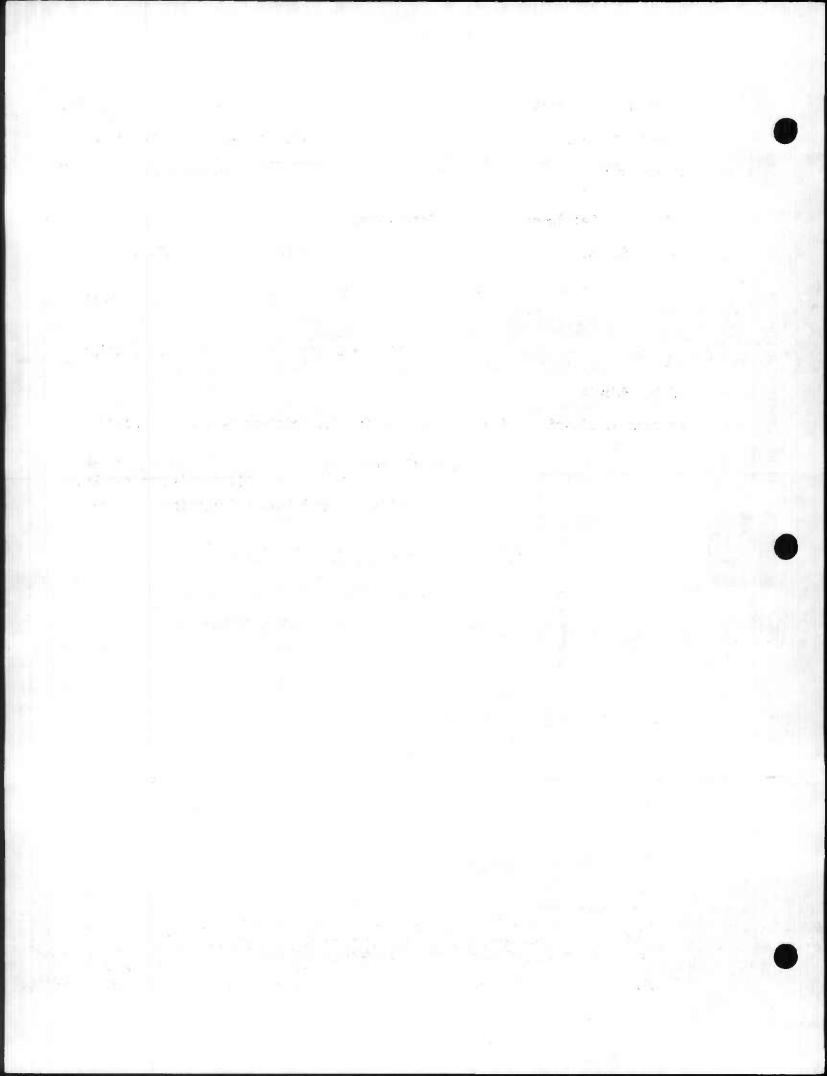
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State

31. Date filed (Month, Day, Year)

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within 2

State Registrar 29b. Sign

SC 31. Dete liled (Month, Dey, Year) APR 05

ss of person

32. Registrer's Signetura Deplanar

who completed cause of death (Item 23a) (Type, Print)

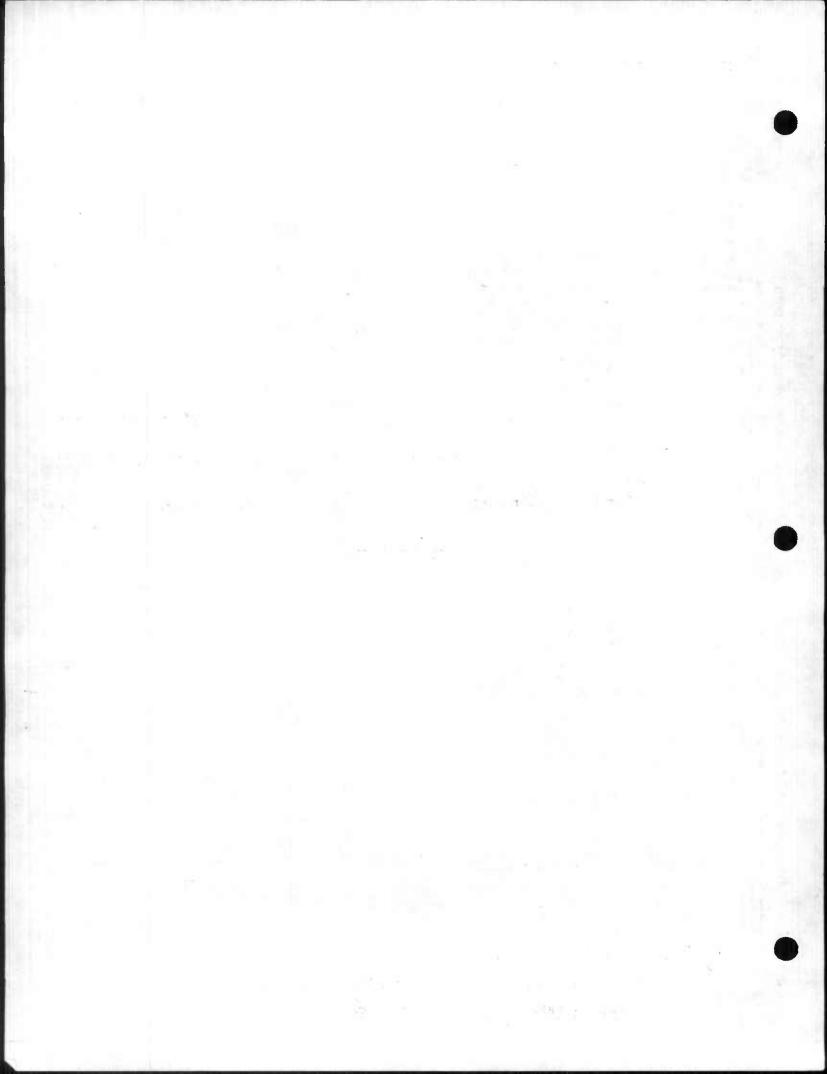
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 02, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month Physician Leas Davis March 29, 1999 5:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore City Baltimore If Under 1 Months B. Date of Birth (Month, Day, Year) June 12, 1947 If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1DM 20F Days 209-38-0022 Yes. 51 Unknown Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show J0d Inside City Limits Unknown 1 ☐ Yes 2 ☐ No terns 23a or 28a-f show Director Unknown Unknown Unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Unknown Unknown U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces? Unknown
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours shar 1∑ Never Married 2 Married altimore. Maryland 21215-0020 "natural", or 1 Yes 200 Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Hem 27 is marked or any Injury or other traumatic eve-Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unknown Unknown 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5X)Other (Specify)[n State 21. Signature of Funeral Service Licensee
Joseph B. Van Sant 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Party Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final CIRRHOSIS OF THE LIVER disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner A LEOHOL ABUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and physician a Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown AFPATITIS C þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1□Yes 200No t ☐ Yes 2 ☐ No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2000 Other: 4 Nursing Home 5 Pesidence & Other (Specify) HOS PICE 10 1 ☐ Inpatient 2 ☐ EPVOutpatient 3 ☐ DOA # 28b. Time of 27. Manage of Death 28a. Date of Injury (Month, Day Year) 2ffc. Injury at Work? 28d. Describe how injury occurred Aftert Certification: Division Attending 1 EdNatural 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funit 1☐ Yes 2☐ No 2 T Accident 6 Could not be 3FT Suicide 28I. Location (Street and Number or Rural Route Number, City or Yown, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 157 Certifying Phyeiclae: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 06933 Kendrulyton in.D. MARCH 29 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

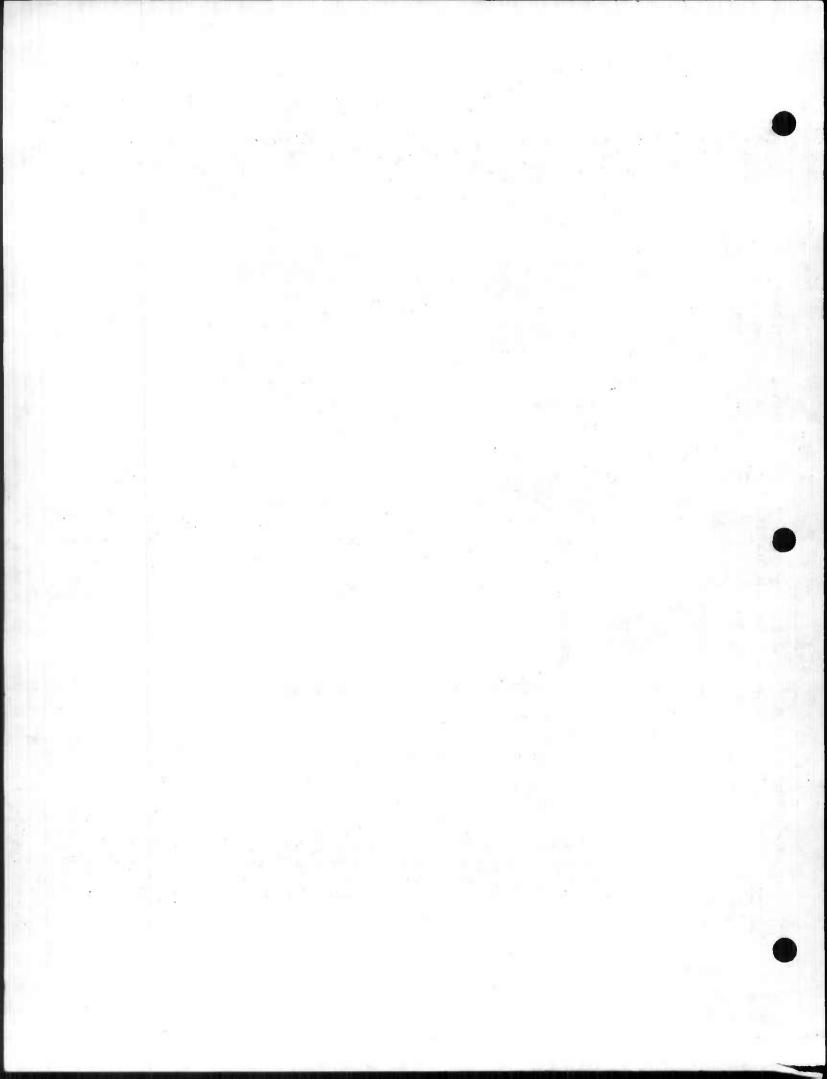
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31. Date filed (Month, Day, Year) APR 0 5 1999

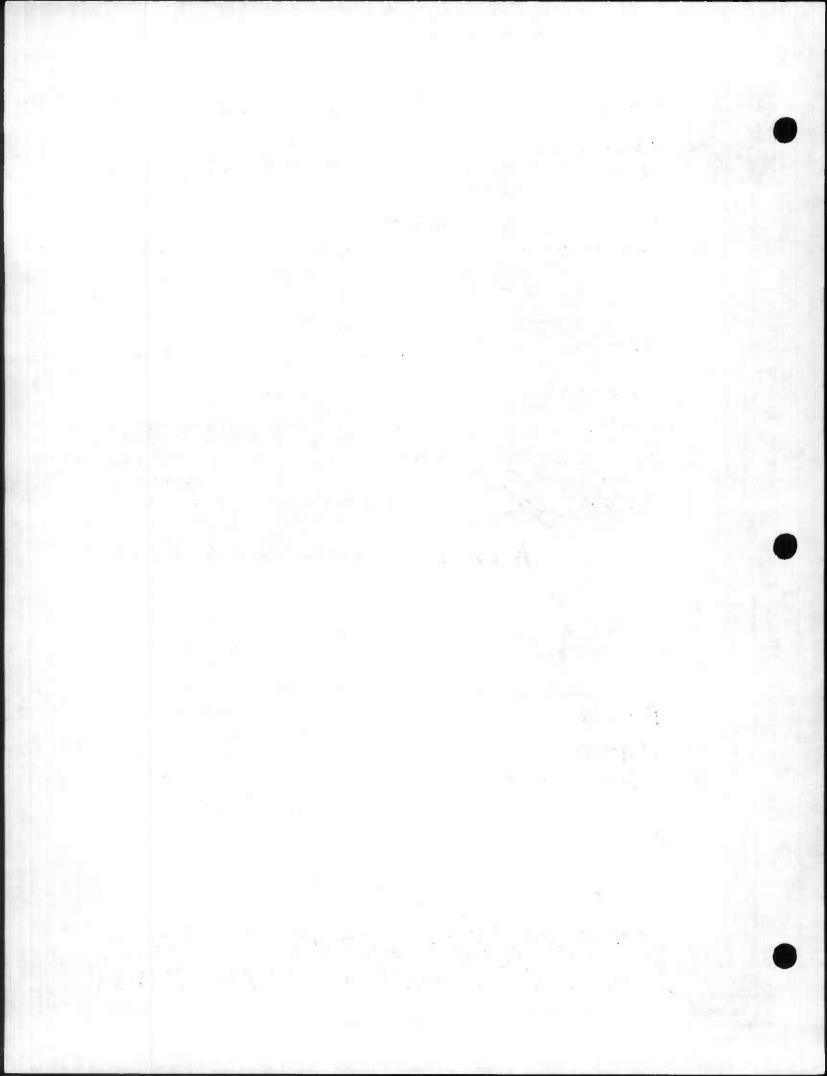
JOHN B. MACGIBBON MD 101 WREAD ST BALTIMORE MD 21201 32. Registrar's Signature

9. Sports



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health a Certificate of Death 1, Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death 3. Time of Death
nysician 'Medical xaminer	Mildred Louise DRESSE	wn, or Location of Deeth 4c. County of Death
neral ector	3704 Overlea Avenue 5. Social Security Number 430-36-2503 1 M 2 Transport	
Name of	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. inside City Limi
rector	MD N/A Baltimore	1 Ves 2 □ N
al Director	10e. Street and Number 10f. Zip Code 21206	10g. Citizen of Whet Country? U.S.A.
by Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Original February (1) in Yes, Specify: 14. Was Decedent of Hispanic Original February (1) in Yes, Specify: 15. Was Decedent of Hispanic Original February (1) in Yes, Specify: 16. Wes Decedent Ever in U,S. Armed Forces? 17. Wes Decedent of Hispanic Original February (1) in Yes, Specify: 18. Was Decedent of Hispanic Original February (1) in Yes, Specify Cuban, Mexicent	gin? (Specify Yes or No- , Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 16a. Decedent's Usual Occupation (Give kind of work done during most lifte. DO NOT use retired) Homemaker	of working 16b. Kind of Business/Industry Own Home
Be Cc	17. Felher's Name (First, Middle, Last) 18. Mother	or's Name (First, Middle, Maiden Sumeme)
To B		ginia Dupree
		er or Rurel Route Number, City or Town, Stete, Zip Code)
	20a Mathed at Disposition 20b Place of Disposition (Name of	ue Baltimore, Maryland 21206 Date 20c. Location - City or Town, State
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) A Parkwood Cemetery	4/2/99 Baltimore, Maryland
dical Examiner	23a. Part 1. Enter the disease, occurring attions that ceused the death. Do not enter the mode of dying, such as shock, or heart failure. List only a cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A the voscle vot Covon word of the covon wo	Ondo did boar
Physician/Medical E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	. 23b. Did tobacco use contribute to the cause of det
by	Hypertersin	24a. Was an autopsy performed? 24b. Were eutopsy finding available prior to completion of cause
Completed	Cerebro, vascula disense	of death?
o Be	examiner?	of Death (Check only one)
edical Certification: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nu 27. Manner of Deeth 1 Nutural 5 Pending (Month, Dey Year) 28b. Time of Injury Work? 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred No 28f. Location (Street end Number or Rural Route Number,
Certi	4 Homicide building, etc. (Specify)	City or Town, State)
edica	29a. Certifier (Check only one) 1	
M	29b. Signature and title of conflier 29c. License number 235 33	29d. Date signed (Month, Day, Year)
	30. Nation and address of person who completed cause of death (Item 33a), (Type, Print)	p. Md. 21239
State gistrar	31. Date filed (Month, Dey, Year) APR 0 5 1999 32. Registrar's Signature	



	G JR.				Cert	ificate	of I	lealth a Death		F	Reg. No. 9 9	10	778	
ıysicia		ama (First, Middla,		10						. Date of Dea Month	Day	Year	Tima of Death	
ica ine	de Feelling News	TERRI TRANKLIN LITIG, UK.								APRIL tion of Death			035 PM	
ne		AST MAIN		INST	ER	CARR								
	5. Social Security 214-92-	5953	. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last 34		If Under 1 Months E	Yaar Days	If Under 2 Hours	Min. J	Data of Birth (Month, Day UNE 28	, 1964	9. Birthplaca Country)	(Stata or Foreign	
-	Usual Rasidance 10a. Stata MD	10b. County	n11	10c. City, To	own or Loc								nside City Limits	
	10e. Street and N					10f. Zip Co	ode 211	57			-	en of What Country?		
Funeral Director	11. Marital Stetus	s arried 2 Marrie	12. Was Decede Armed Force 1	is?		as Deceden Yas, specify		ispanic Orig an, Mexican Specify:	gin? (Speci , Puarto Ri	fy Yas or No- can, atc.)		ce - American Inck, Whita, atc.	70	
S D		4 Divorced	Yaar or Data								Specif	WILLE		
Completed	Elementery/Se	15. Decedant's pecify only highest econdary (0-12)	Education grade completed) Collega (1-40	or 5+)		int's Usual C ind of work of ONOT use i			of working			o Corp.	sinass/Industry	
lo Be C	17. Father's Nam	e (First, Middle, Le						18. Motha		First, Middle,	Maiden Surnan			
		Neme/Ralationship		1	19b. Mailing	Address (S	itreet					, State, Zip Cod	(e)	
		. Emig, S	ir. Fathe					ad Rd	., Re		town, M			
	20a. Mathod of D		☐Ramoval from Sta		of Dispos atary, crami	tion (Nama atory or otha	of ir plac	ce)		Defe	20c. Location	- City or Town,	Stata	
		n 5 Othar (Spe		Carro		remati				7/99		ead, MD		
	21. Signature of	Funaral Sarvice bi	0000	\		Name end A				1182	4 Reist	erstown	Rd.	
		ben Wil	Marie)		ine Fu				Reis	terstow	n, MD	21136	
	23a. Part1 Enta shock, or h	ir tha disaase, or co aart failura. List or	mplications that causely ona ceusa on aacl	sed tha daath. D	o not ante	fhe moda o	f dyin	g, such es	cardiac or	respiratory ar	rast,	inta	roximate rval Between	
	tmmodiate Cour	e (Final		i.								One	et and Death	
	tmmediata Caus disaasa or condi resulting in deet	tion	a	1	ONE	ling								
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CXaminer			b	D	1							i		
Z	Sequentially list if any, laading to cause. Entar Un			Due to (or as	a consequ	anca ot):						1		
		or Injury nts	c	Due to (or es	e consequi	ance of):						+		
. Box 68760, death certificate be associted e attending physicien end of for use as the bunal-transit sician/Medical Examin	rasulting in death	n) Lest		000 10 (01 03	e consequ	arios orj.						1		
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SICIBILIMED	Part II. Other sign	nificant conditions	contributing to death	n but not rasultin	g in the und	dartying caus	se giv	en in Part I.		23b. Did t	obacco use co	ontribute to the	cause of death?	
/ rilysiciarymedical	Part II. Other sign	nificant conditions	contributing to death	n but not rasultin	g in tha und	darlying caus	se giv	en in Part I.		23b. Dld t		ontribute to the		
2		nificant conditions	contributing to death	h but not rasultin	g in the und	larlying caus	se giv	en in Part I.	-	1 1 1 24a. Was		3 Probably 24b. Were a availab comple	utopsy findings	
Š		nificant conditions	contributing to death	n but not rasultin	g in the und	dartying caus	se giv	en in Part I.	-7	1 N	na autopsy med?	3 Probably 24b. Were a availab comple of death	utopsy findings le prior to tion of cause	
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adles Cartification: To Be Completed by	25. Was casa refexaminer? 12 Yes 2 27. Mannar of Dec 1 Natural 24 Accident 3 Suicide 4 Homicide 29a. Cartiflar (Check only one	ierred to medical No sath 5 Panding invastigal 6 Could no datarming	Hospital: 1 Inpi	atient 2 ER/ plury 281 Injury At homa, atc. (Specify) st of my knowled to of axamination	Outpatient Outpatient Injury A Injury	3 DOA 28c. M 28c. M in factory, o	Other Injury World	26. Placa er: 4□ Nur y at k? Yas 2(1)1	rsing Home 28 No 28	24a. Was performed a MA Rasid d. Describe h. City or Tow d dua to the c. lat tha tima, d	an autopsymed? (as 2 \sum No ne) lence 6 \sum Ont covering the new Injury occur covering	3 Probably 24b. Were a availab comple of dealt Ya ther (Specify) ried SPLYX berfor Rural Ro	utopsy findings le prior to tion of cause ?? s 2 No ta Number, 2157	

within 24 hours after death.

To the Funeral Diractor: After this certificata has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The lew requires that the death certificate be executed

State Registrar

31. Dete filed (Month, Day, Year) APR 0 5 1999

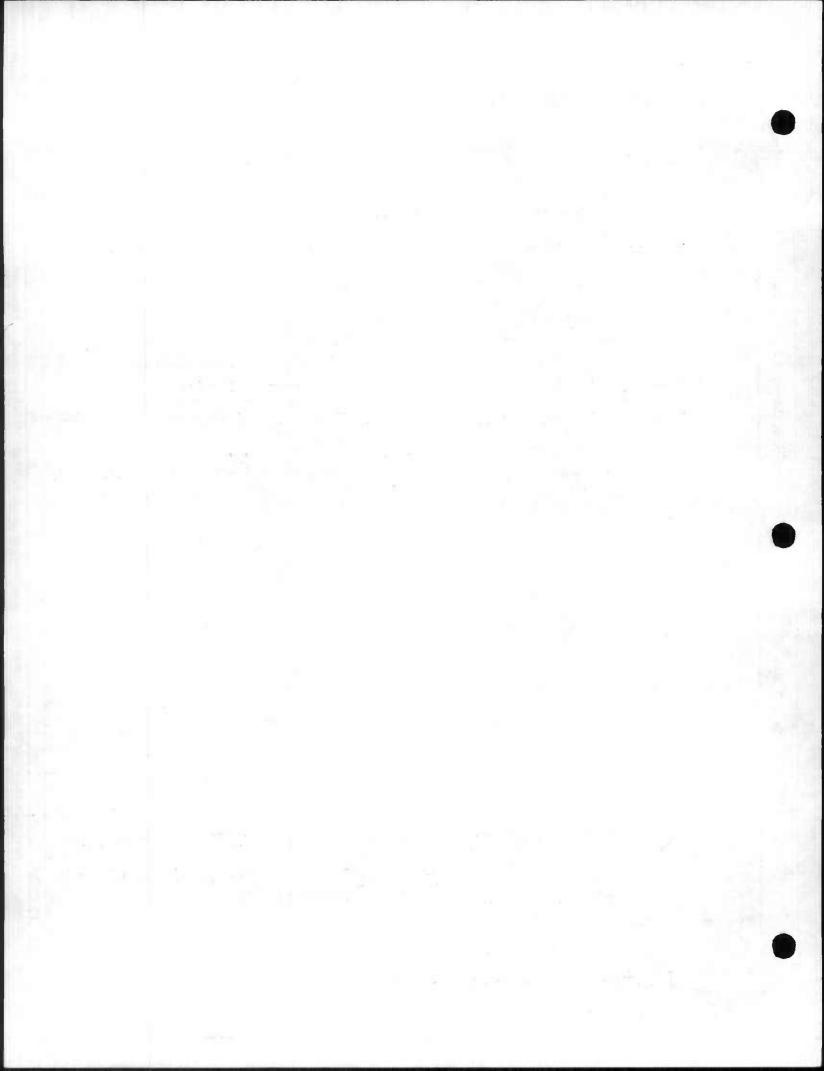
E NO 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

ss of person who complated causa of death (Item 23a) (Type, Print)

Loc

Sports

APRIL 2, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 1235 **Physician** Donald Joseph Eisenhart March /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Hagerstown Washington Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) March 20,1924 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpieca (State or Foreign Country) **Funeral** Deys Hours 196-18-5281 110 M 2 F 75 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21742 1432 Kensington Drive U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 □Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Unknown unknown Unknown unknown marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 88 permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of Earl F. Eisenhart Sarah C. Strock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) James Eisenhart/son 17017 Hillsdale Court, Hagerstown, Maryland 21740 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph B Van 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201 23a. Part1. Where the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and s the burlai-tran Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequenca of): Physician/Medical Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 ☑ Unknown þ Records. 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed peen page 2 s 1 ☐ Yes 2 DUNo 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 15 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 24 hours after death. Funeral Director: After or Attending 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and menner steted. within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) To

State Registrar 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

346

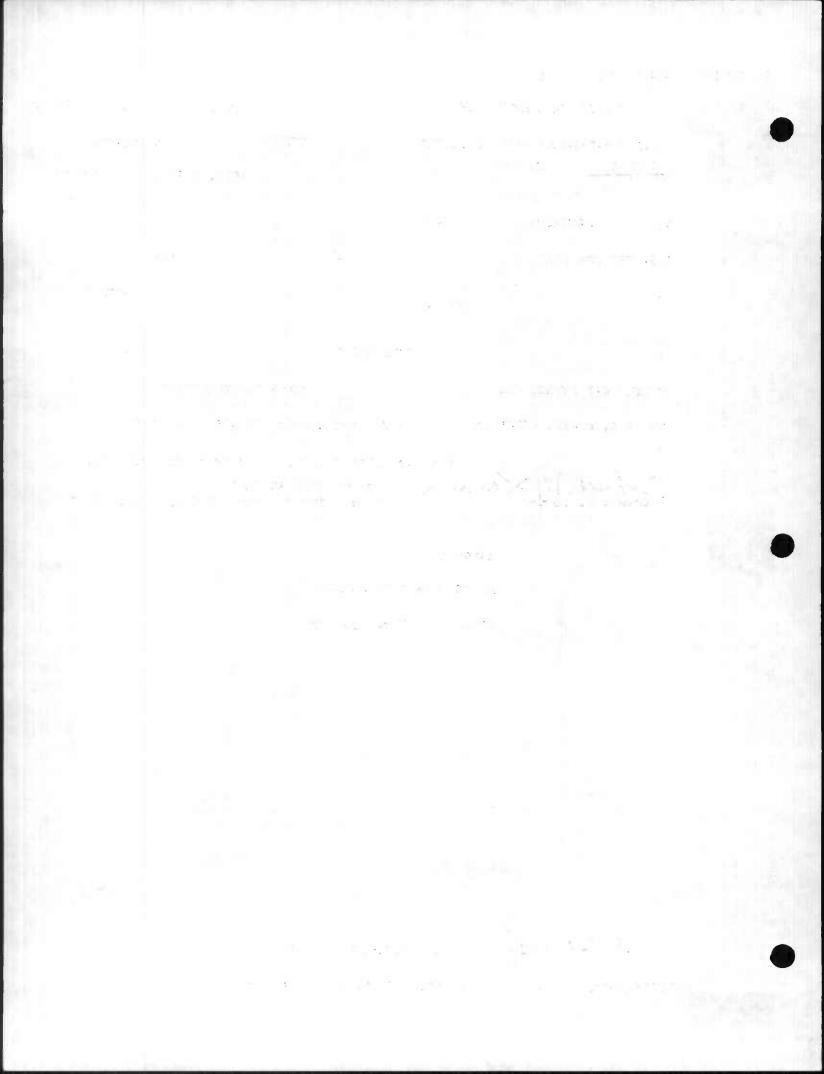
22. Registrer's Signeture

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31. Dete filed (Month, Day, Year) APR 0 5 1999

Frank Strategy s Resign and address of finding • 6

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hysician	1. Dece	dent's Name (First, Mic MTLTON	rest de.						Date of Deetle Month	Dey	Year 1999	3. Time of Deet 6:28PM			
/Medical xaminer	4a Facil	1122201. 0112							b. City, Town,				ity of Deeth		
Examiner	CDE	ATER BALTI	MORF	MEDICAL.	CENT	TER			TOWSO	V		BAI	E		
neral ector	5. Socia 284-	I Security Number 10-250) esidence of Decedent	6. Sex		ige (In yrs.	lest birthday) 9 3 Yrs.	If Unde Months	Deys	If Under 24 H	in.	Date of Birth (Month, Day, FEB. 23)	Year)	9. Birthp	olece (Stete or Fon htry) SOURI	
der 7	10e. Ste				10c. Ci	ty, Town or Lo	cation		100				1	10d. Inside City Lin	
be notified	MD	. BALC	TIMOR	E	SI	PARKS									
Olre	10e. Str	eet end Number					10f. Zi	p Code			10	0g. Citizen o	f Whet Cour	ntry?	
a E	16	52 GLENCOE	ROAD				21	152				USA			
Examiner must be notified at by Funeral Director	3 🖺	ital Status Never Married 2☐ M Widowed 4 ☐ Divorc	Married	12. Was Deceden Amed Forces 1 A Yes 2 I If Yes, Give Yeer or Dates	?] No		Was Dece If Yes, spe 1 Yes		lispanic Origin? en, Mexican, Pu Specify:	(Specit erto Ric	y Yes or No- an, etc.)	В	ace - Americ leck, White, hify: WHI!	etc.	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10b perFH G770 4/5/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Griffin APRIL OI 4:25 PM Annie 1999 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Lorien Medical Specialty Unit olumbia Howard if Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) SEPT 20,1964 5. Social Security Number Birthplaca (State or Foreign Country) Days Months Hours 1□M 20 F 239-80-011 Yrs. South Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Howard 1 ☐ Yes 2 No COLUMBIA WAD MARYLAND 10e. Street and Number 10g, Citizen of What Country? 235 COLEMAN THOMAS ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +# GRADE HOME MAKER OWN 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) WOOD DDISON 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9235 COLEMAN THOMAS RD. COLUMBIA, MD. 21046 (NEICE MINNIE ABRAMS 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete 4 Donation 5 Other (Specify) GUILFORD MEMBRIAL PARK 04-08-97 COLUMBIA, MARYLANI 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Daath Preumonia Aspiration Immediate Cause (Finel disease or condition resulting in death) 3 Weeks Due to (or es e consequence of) Due to (or es e consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Alzheimer's 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

physicien and the buriel-transit

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

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ma 23a or 28a-f ahor

Home 2

"natural", or

permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental hygiene. Important: if item 27 is marked other than "national injury or other treumatic event, on the deal and in the contract of the contract

72 hours after

Baitimore, Maryland 21215-0020

Directo

P

Completed

B

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical PY Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

	examiner?	77	
22	Mannay of	Dooth	

5 Pending investigation 2 ☐ Accident

8 Could not be

APR 5 1999

28a. Dete of Injury (Month, Day Year)

P.SLOW, MD

28c. Injury at Work? 1 Yes 2 No 28d. Dascribe how injury occurred

281. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certified (Check only one)

1 Natural

3 ☐ Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier Sougar

29c. License number DO052940 29d. Date signed (Month, Day, Year) APROL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTAY P. SHAH, MD 10805 Hickory Ridge Rd #210, Columbia, MD21044 31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

8

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Certification:

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Aftert

in 24 hours after death.

he Funerel Director: After plately filled in by the fur

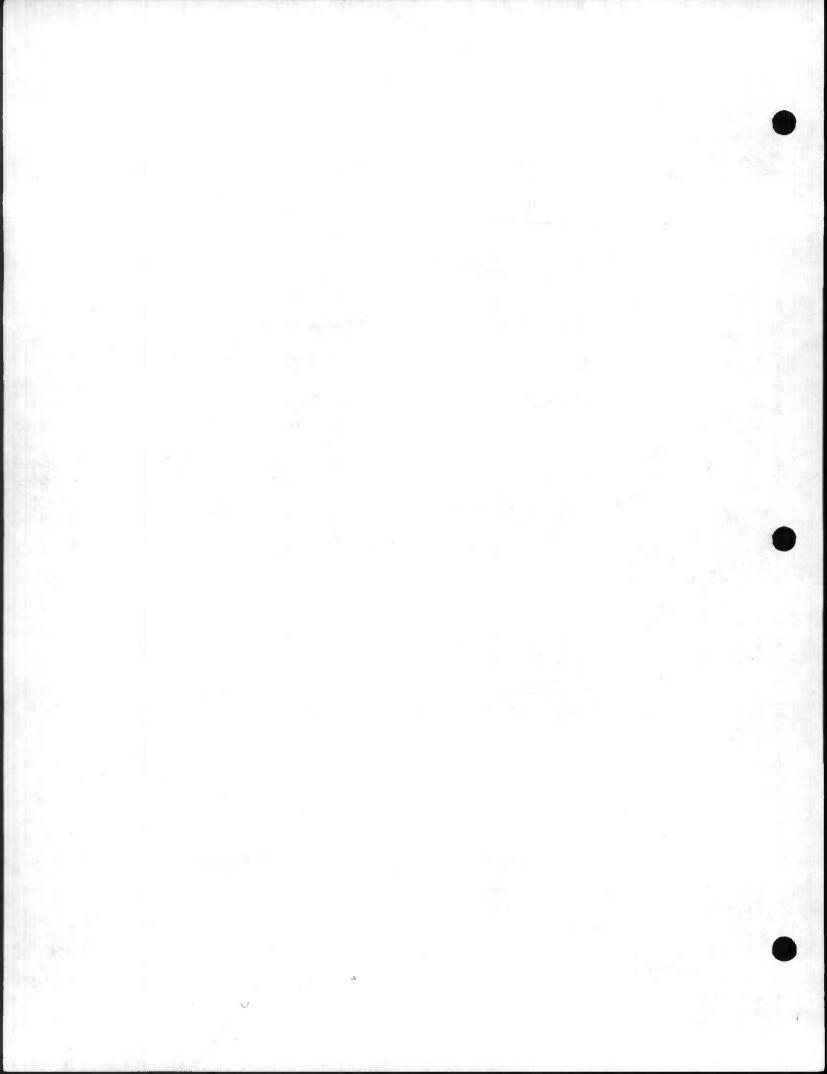
To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After

32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth Month **Physician** Patricia A. Gayo 2, 1999 4:00 AM April /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26973 Dogwood Lane Mary's St. Mechanicsville 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth 7. Age (In vrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 212-32-4610 1□M 201F Months Days Hours Min 63 Yrs. 04/12/1935 Director Baltimore, MD Usual Residence of Decedan with the Marylend 10e State 10c. Cftv. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examiner must be notified at MD St. Marys County Mechanicsville 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 26973 Dogwood Lane 20659 United States Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or Nen any Injury or other traumatic event. It 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Health Care 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fethar's Name (First, Middle, Last) Clifton Blanch Eda Lehman 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Richard I. Gayo, SR 26973 Dogwood Lane Mechanicsville, Maryland 20659 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State 1 DBuriai 2 Cremation 3 Removal from State Holy Redeemer Cemetery 04/06/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 5305 Harford Road, Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that causad the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physiclan** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physicien end s the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that Initiated events resulting in death) Last sequence of) certificate be axec Box 68760. Physiclan/Medicai Due to for as a consaquance of): 88 ed by the attending I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by to 3 Probably 4€Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? peen page 2 has 1 □ Yes 2 🕏 1 ☐ Yes 2 ☐ No After this cartificate Attending Physician: funeral director, 25. Was case referred to medical Be 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Mesidence 6 Other (Specify) 1□ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Disture 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident i or Attend after death Director: / 6 Could not be determined 3 Sulcide 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner states. 29a. Certifier Medical completaly (Check only one) To the I within 2 To the P 29b. Signature and title of 29c. Licansa number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address &

James P.

4035 Three Notch Road, Hollywood, Maryland 20636 M.D. arboe, 31. Dete filed (Month Dey, Yeer) APR 5

1999

seth (Item 23e) (Type, Print)

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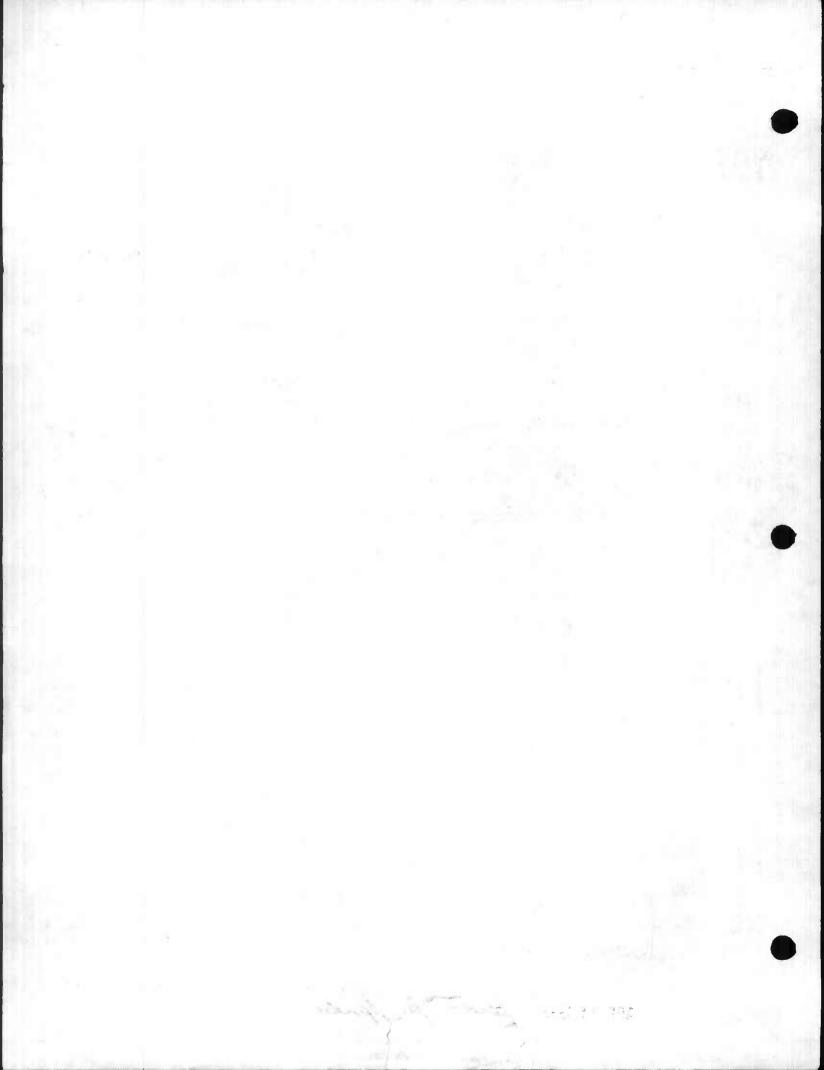
State Registrar 31. Dete filed (Month, Day, Year)
APR 0 5 1999

HAMBOURS

32. Registrar's Supratu.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Q RICHARD ITEMS: #23 PART I GRACZYK Item 21 Per AB FilmG770 405099 rja Certificate of Death

Physician
/Medical
Examiner

Richard Graczyk

2. Date of Death Month

3. Time of Death 6:00P.M.

1 Yas 2 No

Funeral Director

Directo Funeral 5

Completed Be

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nant of Health and Mental Hygiene int: If Hem 27 is marked other than "natural", or items 23e or 28e-1 show ary or other treumstic event, the Medical Examinal must be not fied at any or other treumstic event, the Medical Examinal must be not fied at

Baltimore, Maryland 21215-0020 permit. Page Department of Important: if any injury or once. Physician /Medical Examiner Examiner physician and the buriel-transit law requires that the death cartificate be executed Physician/Medicai 60 usa signed by the a d be deteched f à Completed page 2: cartificete or Attending Physician: funaral director, Be Certification: To this efter daath. filled in by 24 hours e Hospital

Division of Vital Records, P.O. Box 68760

1. Decedant's Nama (First, Middla, Last) MARCH 18, 1999 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) 1628 E.LANVALE STREET BALTIMORE Baltimore If Under 1 Year If Undar 24 Hrs. Birthpleca (Steta or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours Min 1₩ M 2□ F Yrs. unknown unknown unknown unknown Usuai Rasidenca of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore City Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1628 E. Lanvale Street 21213 U.S.A. 11. Maritel Status unknown 12. Wes Decedent Ever in U.S. Armed Forcas? UNKNOWN Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien. Biack, Whita, atc. 1 Yes 2 No If Yas, Giva Yeer or Datas: 1 Never Merried 2 Marriad 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Eiamantary/Secondary (0-12) Collaga (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) unknown unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) unknown unknown 20b. Placa of Disposition (Nama of cametery, cramatory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cramation 3 Ramoval from State 4□Donation 5ৢOthar (Spacify) in state 21. Signatura of Funarai Service Licensae Rona Ld S. Wade, 22. Nama and Addrass of Facility
State Anatomy Board, 655 W. Baltimore Street Director JOseph B. VanSant Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediata Causa (Final NARCOTIC INTOXICATION diseasa or condition rasulting in death) Due to (or as a consequance of): Sequentially list conditions, if any, leading to immadiate ceuse. Enter Undarlying Cause (Disease or Injury that initieted avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No

23b. Did tobacco ues contributs to the causs of death? 3 Probably 4 Unknown

24a. Was an autopsy

26. Pieca of Daeth (Check only ona)

24b. Wera autopsy findings available prior to completion of cause of deeth?

Approximata Intarval Batwaan Onset and Daath

12 Yas 2□ No

1 Yas 2□ No

25. Was casa referred to medical 1 X Yas 2 No 27. Mennar of Death

1 Naturai

3 Suicida

29a. Certifier

edicai

2 Accident

4 Homicide

5 Panding invastigation 6 D Could not be determined 28a. Data of Injury Found: (Month, Day Year) 3-18-99 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

Hospitel: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Р FOUNDY 5:45

Othar: 4 ☐ Nursing Home 5 ☒ Rasidanca 6 ☐ Othar (Specify) 28c. injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred SUBJECT INGESTED DRUGS

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) 1628 E. LANVALE STREET BALTIMORE, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the causa(s) and mannar as steted.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and mannar stated. (Check only one) 29b. Signature and 1918 of certifier

FOUND AT HOME

29c. Licansa number O.C.M.E. 29d. Data signad (Month, Day, Year)

MARCH 19,1999

30. Nama and addrass of person who complated causa of daeth (Ibani 23a) (Type, Print)

THEUNORE 31. Data filed (Month, Day, Year)

0

5 1999

32. Bigistrer's Signatura

State Registrar

To the Hosp within 24 ho To the Fune complately f

Physician

/Medical

Examiner

Funeral

Director

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natural', or itema 23a

I Hygiene.

Pages 1 end 2 should be nent of Heelth and Mental

Depertment

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Important: If Item 27 eny Injury or other to page.

filed within 72 hours after

Baltimore, Maryland 21215-0020

Funeral Director

8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey 1999 APRIL 03, ESHA 06:38 AM 4c. County of Death 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth BALTIMORE CITY CORRECTIONAL FACILITY BALTIMORE 7. Age (In yrs. last birthdey) 2. (Yrs. If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Dev. Birthplace (State or Foreign Country) 2 10 M 2 F Days 272 - 76 - 09 Usual Residence of Decedent Hours -76-0920 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Stetus Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Şeçandery (0-12) 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GILBERT 19e. Informent's Neme/Reletionship (Type, Print) (MOTHER) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE. ENRIETT 1236 Bonaparte IMD 2/2/8 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Date 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) METRO CREMATORY 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility LBERT GilMOR 638 MD 21217 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) HAS WILL Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Neturel Sunsver Hower SELE. 6:10/ 1 Yes 2 No tours 4-3-99 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

The law requires that the death certificate be executed Box 68760, signed by the a Division of Vitai Records, P.O. or Attending Physician: this within 24 hours efter death. To the Funerel Director: A Hospital To the

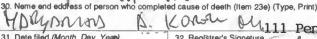
> State Registrar

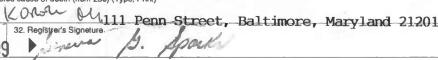
HARYANIN 31. Dete filed (Month, Dey, Year)

29b. Signature end title of certifie

4 Homicide

(Check only





1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

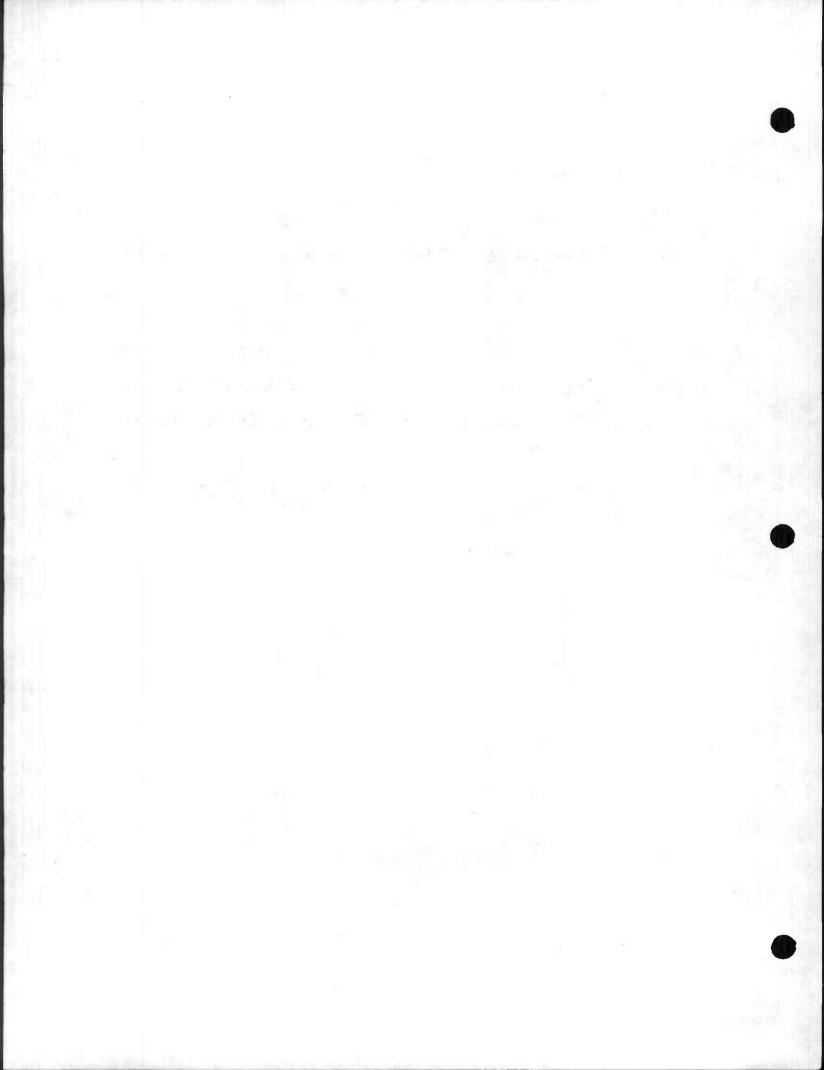
OCME

29c. License number

DETENTION CONTEN BLANDRECITY

29d. Date signed (Month, Day, Year)

APRIL 04, 1999



State of Maryland / Department of Health and Mental Hygiene	0	0
Certificate of Death Reg. No.	9	9

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Physician /Medical	
Examiner	

Hassan Melvin Hasan 4a Facility Name (If not institution, give street end number)
3133 RAVENWOOD AVENUE

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death BALTIMORE

2, 1999 ear 10:50 AM

Funeral Director

ahow

r 28a-f ahow

r than "natural", or items 23s or the Medical Examiner must be

filed within 72 hours after of Hyglena. Ither than "natural", or hea

. Peges 1 and 2 should be filed w iment of Health and Mantel Hygler tant: If Nam 27 is marked other th Jury or other traumatic event, the

Department of Important: If any injury or

Physician /Medical

Examiner

sloian end burial-transit

physician s the burial

signed by the a

should

certificate

Aftar this

24 hours eftar death.

within 2 4

Hospital

funeral director,

filled in by

S 980

The lew requires that the deeth certificate be executed

Box 68760.

Records, P.O.

Division of Vital or Attending Physician: Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

21215-0020

Baltimore, Maryland

Director

Funeral

þ

Completed

Be

death with the Marylend

Usual Residence of Decedent 10a State 10b. County

220.20.3039

10c. City, Town or Location

8. Date of Birth (Month, Day, Year)

2. Date of Death

APRTI.

 Birthplace (State or Foreign Country) Md

Md. n/a

Baltimore

Rigger

Yrs.

7. Age (In yrs. last birthday)

70

10d Inside City Limits XX Yes 2 No

10e. Street and Number

5. Social Security Number

3133 Ravenwood Avenue

10f. Zip Code 21213

Months

10g. Citizen of What Country? USA

4c. County of Death

1928

11. Maritel Status

1 Never Merried 2 Married 3 Widowed 4 Doworced

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed)

lementery/Secondery (0-12) College (1-4or 5+) 9th Grade

6. Sex

₩ 2□F

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry Baltimore Riggings Co.

17. Father's Name (First, Middle, Last)

Theodore Brookins 18. Mother's Name (First, Middle, Maiden Sumeme)

Bessie Griffin

19e. Informent's Neme/Relationship (Type, Print) Daughter Marilyn B. Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3621 Robin Air Court Pasadena Md. 21122

20a. Method of Disposition Buriel 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) King Memorial Park

20c. Location - City or Town, State April 5 Baltimore, Md.

21. Signature of Funeral Service Licentum

22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

cross 23a. Pert1. Enter the disease, or complications that caused the thind Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line

Arteriosclerotic Cardiovascular Disease

Approximate Intervat Between Onset end Death

tmmediate Cause (Finel disease or condition resulting in deeth)

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or es e consequence of)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2XXNo 3 Probably 4 Unknown

24a. Was en eutopsy performed?

INSPECTION

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 ☐ Yes XX No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? WYes 2□ No

27. Manner of Death

1XXVatural

2 Accident

3 Suicide

4 Homicide

5 Pending

6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) Investigation

Other: 4 Nursing Home XX Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and little of certifier

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) APRIL 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D.

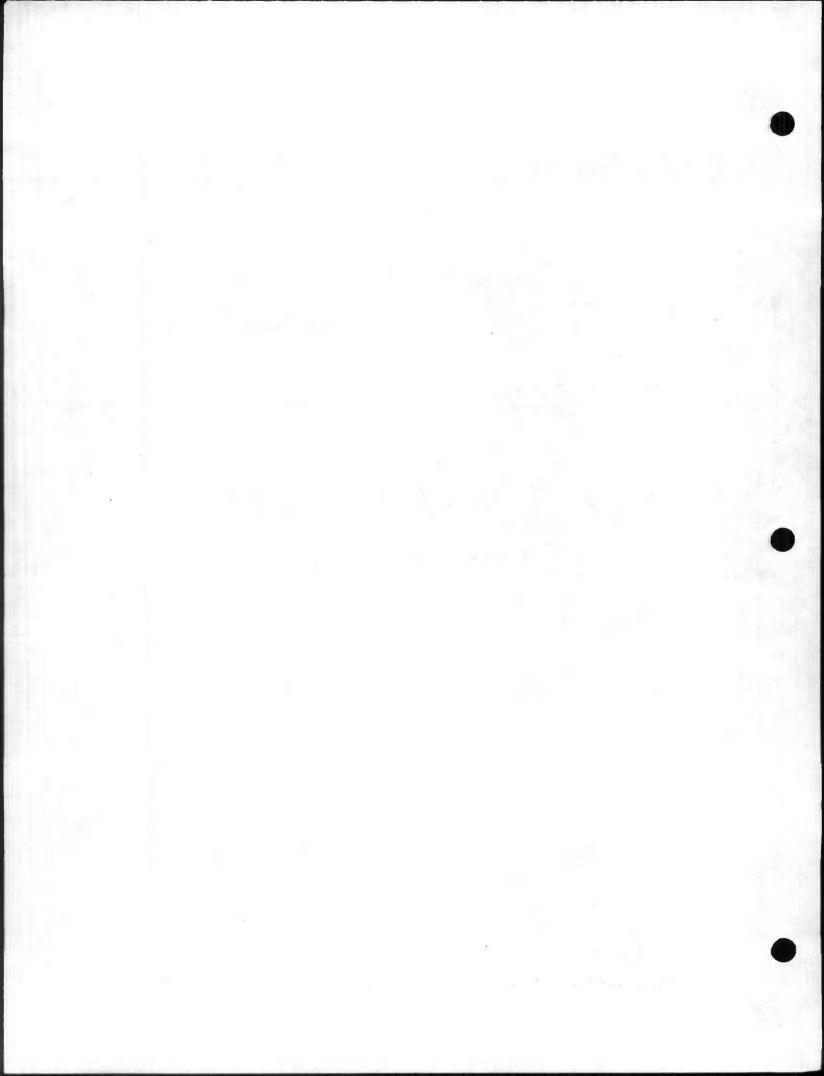
111 Penn Street, Baltimore, Maryland 21201

State Registrar

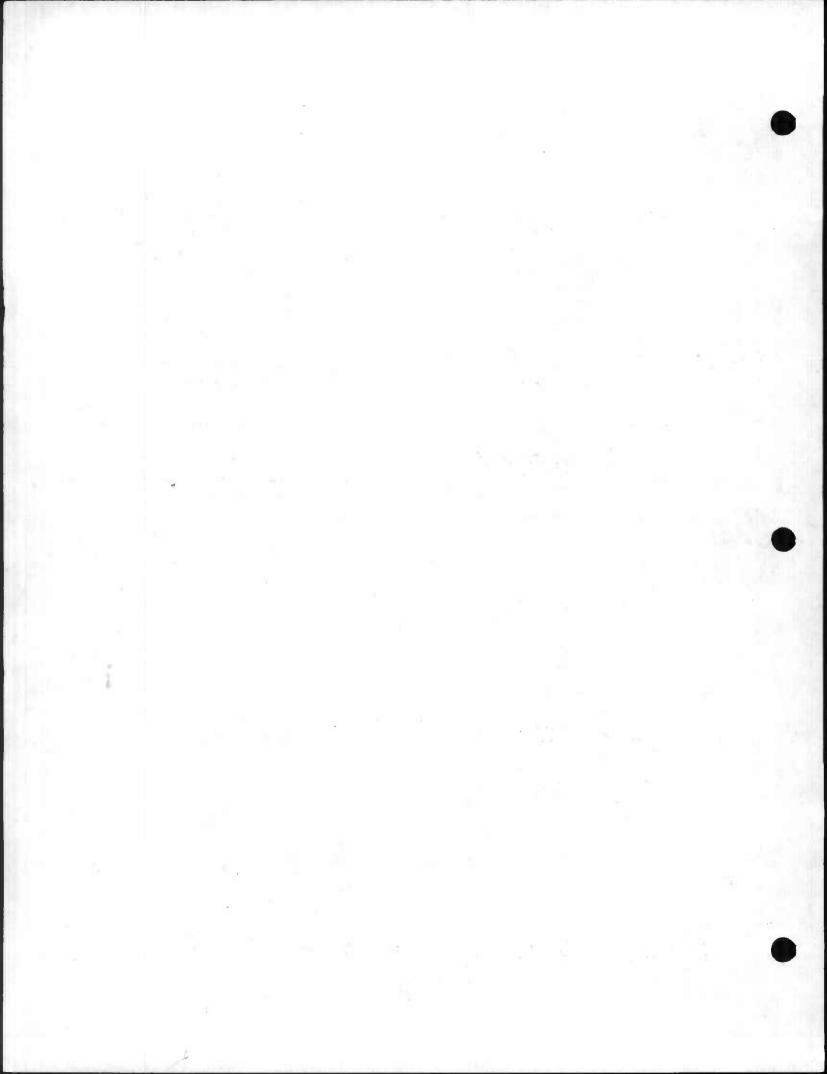
31. Dete filed (Month, Dey, Year) 1999 APR 5

mode

32. Registrar's Signature

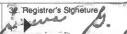


	State of Maryland / Depa Cen	rtment of t		Hygiene Reg. No.	0 10787		
Physician /Medical	Decedent's Name (First, Middle, Last) Idella	I	2. Dete Mon Hilton Marc		Yeer 3. Time of Deeth 6:50 PM		
Examiner	4e Fecility Neme (If not institution, give street end number) Salisbury Center: Genesis ElderCare		4b. City, Town, or Location of Salisbury, MD	n of Death 4c. County of Death			
Funeral Director	5. Sociel Security Number Unknown 6. Sex 1□ M 2反 F 7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days		of Birth th, Dey, Year)	9. Birthplece (Stete or Foreign Country) Maryland		
notified at	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Loc Maryland Wicomico Salisbury				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
the notif	10e. Street end Number 200 Civic Avenue		10g. Citizen of W	/het Country?			
Counties must be notified by Funeral Director	11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 11 Yes 22 No	21817 Vas Decedent of Yes, specify Cub	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et Specify:	or No- 14. Race	e - American Indien, k, White, etc.		
Completed	(Specify only highest grade completed) (Give killer Difference of the complete	ent's Usuel Occu kind of work done O NOT use retire	pation during most of working d)	16b. Kind of Bu			
To Be C	17. Fether's Neme (First, Middle, Last) William James Allen Conner	nager	18. Mother's Neme (First, A Ida Mae For	Middle, Maidan Sumem			
			t end Number or Rural Route				
To Be C	20a. Method of Disposition 20b. Place of Dispos	N. Pine ition (Name of valory or other pla	hurst Avenue, Date		1ary1and21801 City or Town, State		
one			omy Board, 65 Maryland 212		nore Street		
hed for use as the burial-transit and for use as the burial-transit and property sician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of the cause (Disease or injury that initiated events resulting in death) Last	vence of):			7 months		
/ Physician/Me	Part II. Other algoriticant conditions contributing to death but not resulting in the un	derlying cause gi	ven in Part I. 23b	Did tobacco use con	stribute to the cause of death?		
Completed by	Denonto		24a	. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
Be Comp	25. Was case referred to medical of Police		26. Place of Death (Check	1 Ves /25 No	10 Yes gel No		
5	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3□ DOA Ot	her: 40 Nursing Home 50	Residence 6 □Othe	The state of the s		
completely litted in by the funera Medical Certification:	27. Manner of Death 1]Yes 2□No		er or Rurel Route Number,			
edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death only one) Medical Examiner: On the best of examination and/or invested and manner stated.	occurred et the ti astigation, in my	me, data end place, and dual opinion, daath occurred et tha	to tha causa(s) and ma time, data end place, s	nner as stated. and dua to the causa(s)		
Me	29b. Signeture end title of certifier	29c, Licen	39863	29d. Date signed	(Month, Dey, Year)		
State	30. Nema and addrass of person who completed causa of death (Itery 73a) (Type, P ANA (NE) (O l legislature) 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture	Print)	e Splis	mo a	26854		
Registrar	ADD 05 1999 Down B.	hour	/				



Please '	Туре	or	Print	in	Black	Indelible	Ink.	Assure	All	Copies	Are	Legibl	e
	_											00	

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Item 11 Per FH FilmG770 4-15-99 rja 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey 1999 APRIL **Physician** 2, 8:45 P.M. ACKSON LESLIE JAMES /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner FORT HOWARD BALTIMORE VAMHCS FORT HOWARD DIVISION If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Sex 1 ☑ M 2 ☐ F **Funeral** Deys Months Hours 35 SOUTH CAROLINA Yrs. 216-30-6754 Director Usual Residence of Decedent d 2 should be filed within 72 hours efter death with the Meryland and Mental Hygiens.
7 is marked other than "natural; or fleme 23s or 28s-1 show traumatic event, the Medical Example, mast be notified. 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 12 Yes 2 No Directo MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 15A. OURT Funeral 12. Wes Decedent Ever in U,S. Armed Forces? ↑VI Yes 2 □ Nog - 23 - 54 I Yes, Give Yeer or Detes: //-/2 - 57 14. Rece - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married № Married Maryland 21215-0020 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK þ 3 ☐ Widowed - 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 THGRADE ENGINEER BETHLEHEM STEEL 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be filk iment of Health end Mental Hillant: If item 27 is marked oth Be LESLIE TACKSON CURBEAM 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1 BESAN COURT BALTIMORE, MD. 21244
Dete 20c. Location - City or Town, Stete (DAUGHTER) 2 DAWN JENNETTE 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Department of Important: If it any injury or o 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State GARRISON FOREST CEME 4 Donetiga 5 ☐ Other (Specify) 04-09-990 WINGS MILLS, 22. Name end Address of Fecility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIHORE, MD. 2121 30 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory exest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical LUNG CANCER 12/96 Examiner Due to (or es e consequenca of): Examine physician end the buriel-trensit The law requires that the death certificete be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequença of) P.O. Box 68760 Physician/Medical Due to (or es e consequence of) as USB Po 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by 1 1 Yes 2 No 3 Probably WUnknown Division of Vital Records, à 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? pege 2 s hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 5 Pending 1 XNaturel 1 ☐ Yes 2 ☐ No investigetion rector: A 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) within 24 hours efter of To the Funeral Direct completely filled in by 4 Homicide To the Hospital 29a. Certifier 🔀 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted. edical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture engititle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURESH SHANDELYA, M.D.--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State APR 5 1999 Registrar



* - \frac{1}{2}

99-1864-005 Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene ATTUS Certificate of Death KANE Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month De **Physician** TUS MARCH 1999 30. 9:33 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4142 MCDOWELL LANE BAL7 If Under 24 Hrs. TIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthpleca (State or Foreign Country) **Funeral** Months Min Days 1€ M 2□ F 8 Hours 218-36-4978 Yrs. Director Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow 1 Yes 2 □ No Director 28a-f MARYLAND 10e. Street and Number 10g. Citizen of What Country? ò 4142 DWELL USA

14. Raca - American Indien,
Bleck, White, etc. Barres 23a 122 Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 72 hours after 1 Nevar Merried 2 Married Baitimore, Maryland 21215-0020 'natural', or 1 Yes 2 XNo Specify: à 3 Widowed 4 Divorced ACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hyglene. filed within Elementery/Secondary (0-12) College (1-4or 5+) OTHGRADE CONTRACTOR COMPANY . Pages 1 and 2 should be filled wi tment of Health and Mental Hygien fant: If Item 27 is marked other th jury or other traumatic event, the DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TTUS SCURR 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 WASHINGTON AVE. AMY GLEN BOLKNIE, MD. 21060 20c. Location - City or Town, Steta Important: If Item 27 any injury or other tr PARKER 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete HAVEN CEMETERY 04-03-99 GLEN BURNIE, MD. 4 Donetice 5 ☐ Other (Specify) 22. Name and Address of Fecility
TOSE P.H. H. 21. Sign at Fundral Service Lig BROWN JR. FUNERAL HOME FULTON AVE. 140 BALTO, MD. 21217 N. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** Atherosclerotic Cardiovascular Diseas /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) physician a Box 68760. Physician/Medical Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 500 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24a. Was an autopsy performed? page 2 1 Yas 2.25No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yos 2□ No After this funeral 28a. Dete of Injury (Month, Day Year) 27 Manner of Death 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 1 29 Naturel 5 Pending invastigetion 24 hours after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

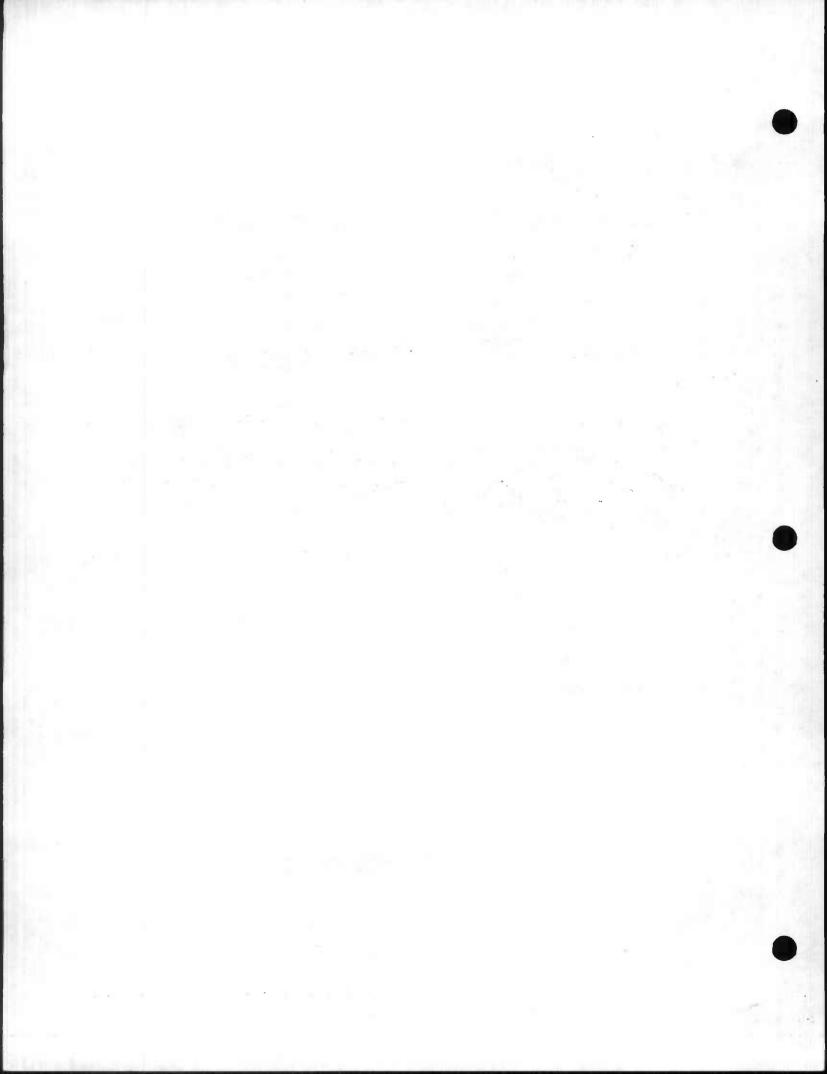
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stafed. 29a. Certifier edical completely (Check only one) within 2 To the 29b. Signeture and title of certified 29c. License number 29d. Dale signed (Month, Day, Year) hutome **OCME** MARCH 31, 1999 Enne 30, Neme and address of person who completed causa of death (Item 23a) (Type, Print)

State Registrar

Chute Dennising 31. Date filed (Month, Day, Year) APR 1999

MD 32. Registrer's Signatura

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month RhodA KANE 9:30 AM Apri 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ST. ELIZABETH REHABILITATION & NURSING CTR. N/A 5 Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 1 M 20 F Months Days Hours 212-16-5700 93 OCT. 29,1905 MARYLAND Usual Rasidanca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21061 U.S.A. 608 GLENVIEW AVENUE 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: Was Dacedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 1 □ Navar Marriad 2 □ Married 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16b. Kind of Businass/Industry 15. Decadent's Education 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) (Specify only highest grada complated) Elamentary/Secondary (0-12) Collega (1-4or 5+) RING CANDY CANDY MAKER 17. Fathar's Nama (First, Middla, Last) 18 Mother's Nama (First, Middla, Maidan Sumama) GEORGE WARFIELD MARY ELIZABETH THOMAS 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) EDITH F. LAMBERT (DAUGHTER) 608 GLENVIEW AVENUE, GLEN BURNIE, MD. 21061 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL CEMETERY BALTIMORE, MD. 21. Signatura of Funaral Sarvica Licenses 22. Nama end Addrass of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batween Onsat and Daath Immediata Cause (Final CONGESTIVE HEART FAILURE disaasa or condition rasulting in death) heart disease Years Severe CORONARY Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaase or Injury that initiated evants rasulting in daath) Last THEROSCIEROSIS 3 everalized Dua to (or as a cons Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MY OCARDIA/ INFARCT 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy parformad? brillation Multi ormochronic ANEMIA 1 Yas 1 Yas 2 HO INFARCT ementiA. 25. Wes casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Beath 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 D Homicida

Box 68760. P.O. Records, Division of Vital Attending Physician: al or Attendi s eftar death il Director: A Hospital of 24 hours e
 Funeral D

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Examiner

Physician/Medical

by

Completed

Be

70

Certification:

edicai

29a. Cartifiar

(Check only one)

funeral

Aftar

death.

To the Hosp within 24 hor To the Fune completely fi

Funeral

Director

? le marked other than "naturel", or items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be need of Haalth and Mental

Baltimore,

rtant: If kem 27

Physician /Medical

Examiner

ician and burial-transit

physician tha burial

signed by

State Registrar 31. Data filed (Month, Day, Year)

APR 0 5 1999 APR Q

29b. Signature and title of certifier

N. M. MACHIRAN 2. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

DR. N. MACHIRAN

720-0 MAIDEN Choice LA.

1 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, end due to tha causa(s) and mannar as stated.

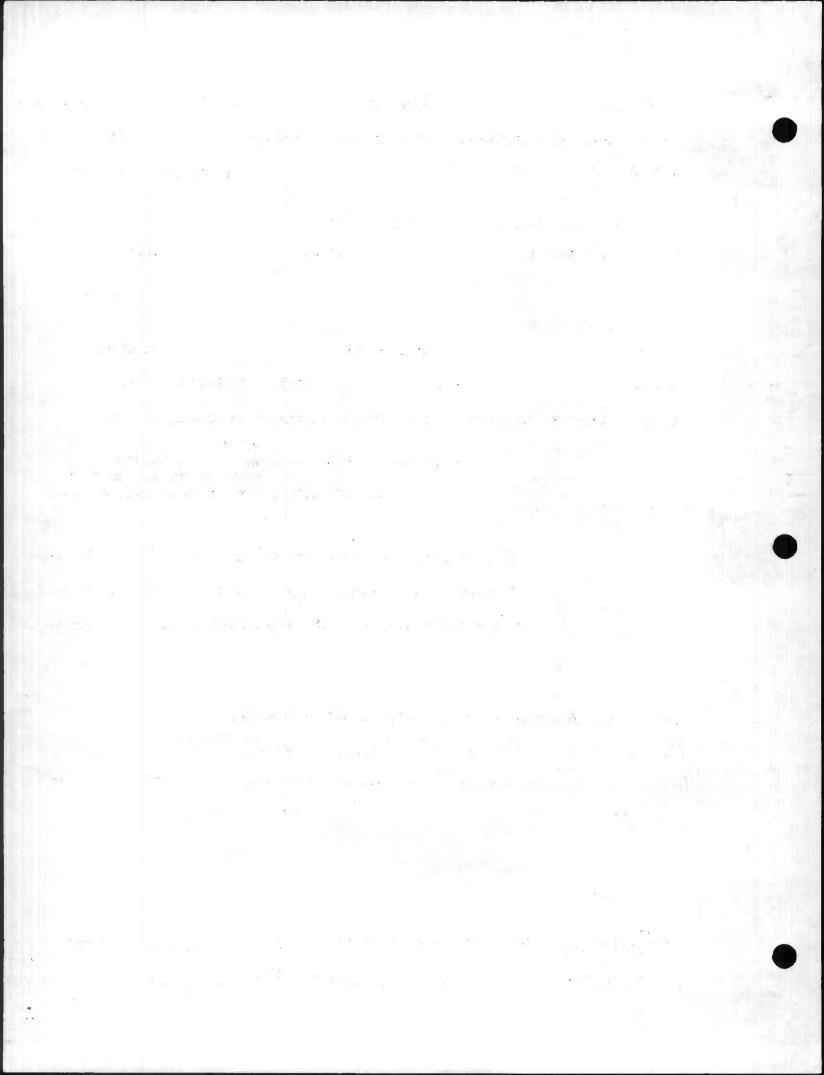
2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred et the tima, date and placa, and dua to tha ceuse(s) and manner statad.

29c. Licansa number

29d. Data signad (Month, Day, Year)

APRIL

2,1899



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 110 Wallace Kidwell march 28 1999 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Caton Manor Nursing Home Baltimore City Baltimore 8. Date of Birth (Month, Day, Year) Feb. 14, 1909 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 9. Birthplace (Stata or Foraign 7. Aga (In yrs. last birthday) 1 M 2□ F Months Days Hours Min 216-05-6331 90 Yrs. unknown Usuai Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Baltimore City Baltimore 1 X Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3330 Wilkens Avenue 21229 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? unknown 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian Biack, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ₩ Widowad 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Bud Morris/nephew 1915 Monumental Avenue, Baltimore, Maryland21227 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 □ Donation 5 □ Other (Specify) in state 22. Nama and Addrass of Facility State Anatomy Board 655 W. Baltimore Street 21. Signatura of Funarai Sarvice Licansee Joseph B. Van Sant Ain Baltimore, Maryland 21201 23a. Part1. Entar tha disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaese or condition rasulting in death) Squamore Cell Carinoma of headerd beek mentho Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Diseasa or injury that Initiated avents rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Seizmes 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

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Funeral

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Physician/Medical

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Certification:

Medical

Funeral

Director

Nem 27 is marked other than "natural", or Nems 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

permit. Peges 1 and 2 should be filled within 72 hours effer death with a Department of Health end Mentel Hygiene. Important: If frem 27 is marked other than "natural" any Injury or other traumatic events.

Physician /Medical

Examiner

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the death certificate be execu Hospital or Attending Physician: efter deeth. Director: Aft 24 hours within 2 To the

> State Registrar

31. Data filad (Month, Day, Yaar) APR 0 5 1999

29b. Signature and title of ognition

4 Homicida

29a. Certifiar (Check only one)

32 Registrar's Signatura

30. Name and addrass of person who complated causa of death (itam 23a) Typa, Print) 3350 Wilkers
DR. OCHANEY COMPANIES COMMENTE, MD 213 Battimore, MD

1 Cacrifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

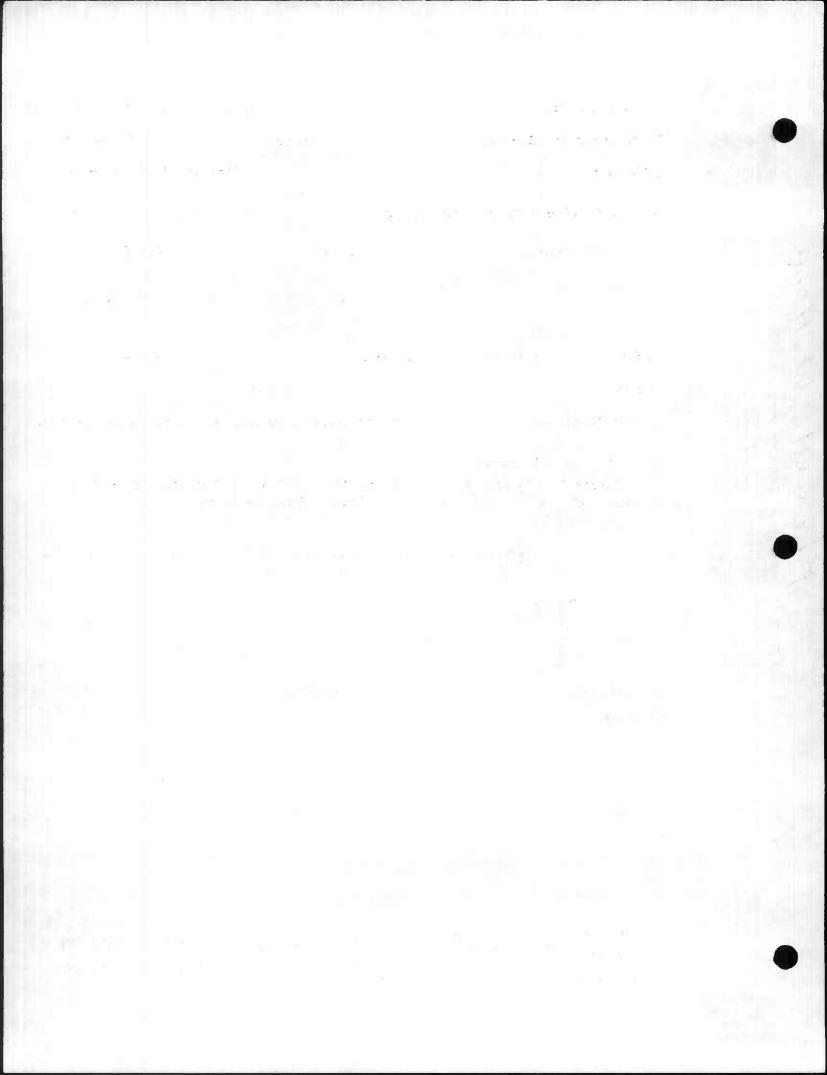
29c. Licansa number

D-40521

29d. Data signed (Month, Day, Year)

March 28, 1999

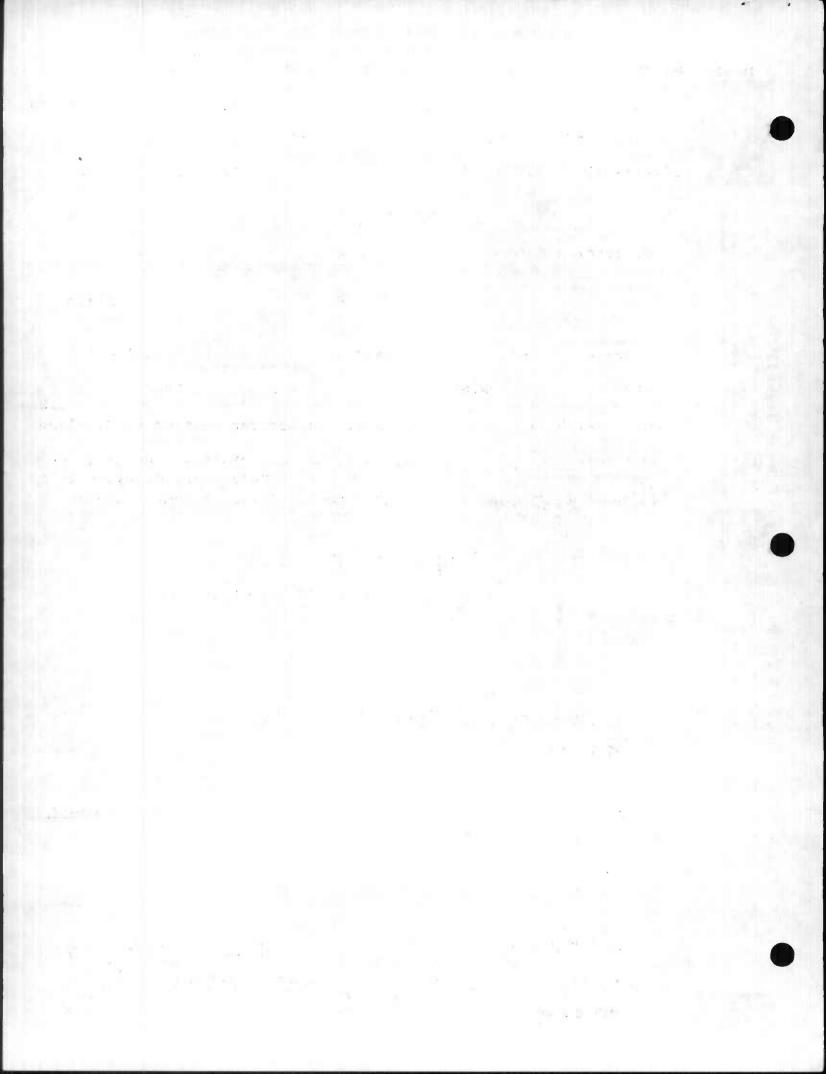
ens Avenue Juite 302



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#26 perPhy G770 4/5/99EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 13, Lowder 99 March 11:35am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1 M 2 □ F Months Hours 71 257-44-9432 03-27-27 GA Director Usual Rasidance of Dacedant Marylend 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23s or 28s-f show ner must be notified at MD NA Baltimore XGYes 2 No Director the 10e Street and Number 10f Zio Code 10g, Citizen of What Country? with 2423 Barclay Street 21218 USA Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status 12. Wes Dacedent Ever In U,S. Armed Forces? Examiner Black, Whita, etc. 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☐ No Specify: f Yes. Give Specify: À 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry at Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) 5th Grade Disabled Unemployed permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, bings. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) John Lowder Lillie 0 Coney 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21218 19a. Informant's Name/Ralationship (Type, Print) Audrey A. Hall 2423 Barclay Street Baltimore, Maryland 20b. Place of Disposition (Neme of cemetary, crametory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 03-18-99 Dundalk, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signetura of Funaral Service Licensee 2 mond WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease, or of pulcetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liston, one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner that the death certificate be axecuted ettending physician end for usa as the buriel-trans Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Due to (or as e consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? o the detached 1 Yee 2 No 3 Probably 4 Unknown signed by Records, ð 8 The law requires 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to Completed peen completion of cause of deeth? has 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) 1□ Yes 2No Hospital: Other: 4 Nursing Home 5 Residence Other (500) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Ă DOA P within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Dey Year) 27. Menmer of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attanding 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital edicai 29a. Cartifian 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d, Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Redistrar's Signatur State APR 0 5 1999 Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** ROBERT LANDSMAN, SR. **JOSEPH** April 1999 5:20PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Northwest Nursing & Convalescent Center Baltimore Baltimore If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 X M 2 F Months Director 215-30-2598 March 17, 1934 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in Mexical Examiner must be notified at enter 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County MD Baltimore 1 ☐ Yes 2 ☑ No Woodlawn Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7003 Gaumount Rd. 21207 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: þ 3 □ Widowed 4 ₺ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction 12 Contractor 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Raymond Landsman Dorothy Paff 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Jay C Landsman

20a. Method of Disposition

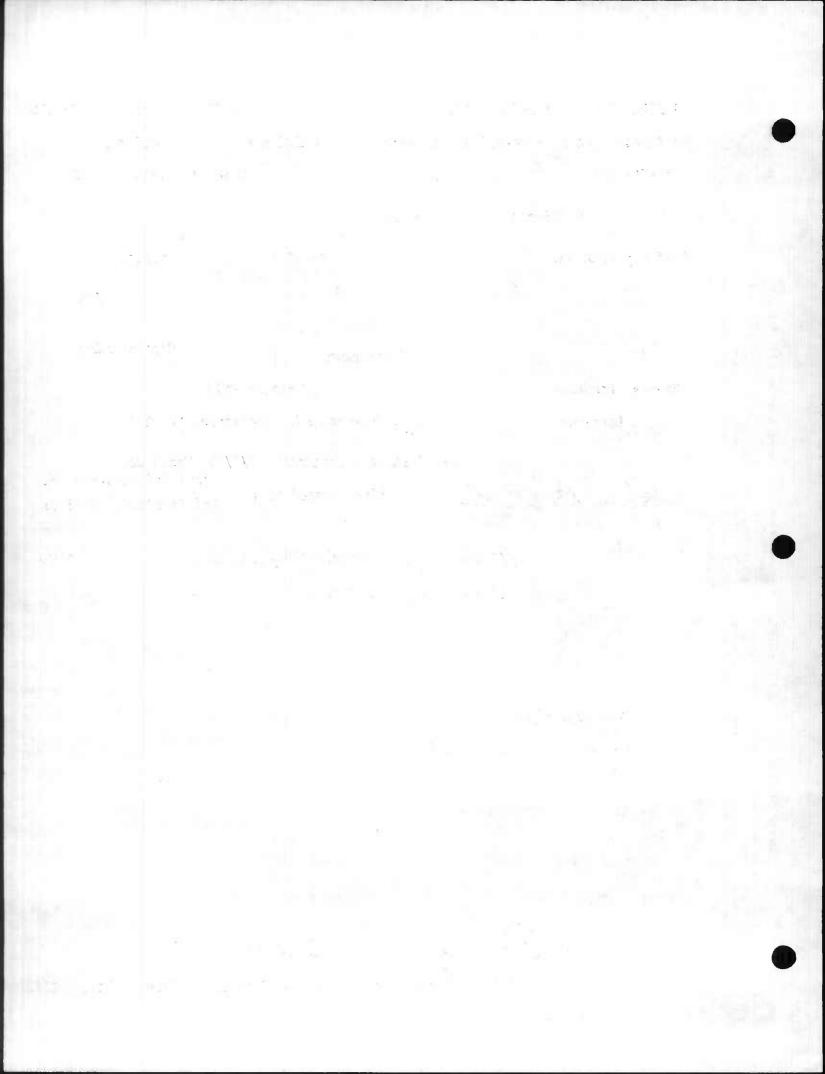
1X Buriel 2 Cremation 3 Removal from State Hernwood Rd., Woodstock, MD 21163 3601 HELNWOOD |
20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Alphonsus Cemetery 4/5/99 Woodstock, MD 22. Neme end Address of Facility 21. Signature of Funerel Service Licanses 11824 Reisterstown Rd. Eline Funeral Home Samo Reisterstown. MD 21136 Int1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, lock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 40 Cardial Examiner Examiner Due to (or es a consequence of) ettending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760. Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings eveileble prior to completion of cause of death? been sig 24e. Wes en eutopsy performed? Completed hes is certificate he 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1□ Yes No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this : After this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Yes 2 No within 24 hours efter death.

To the Funeral Director: Al investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted. (Check only one) To the P within 2 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Name end eddress of person who completed cause of dealt (1) em 23e) (Type, Print) 2717 Hammonds Ferry, Balt., MD21227

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) APR 05 1999 32. Registrar's Signeture



State Registrar

DRUDMAD 31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

APR 0 5 1999

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

LORFU Maryland 21201 32. Registrar's Signeture pearan

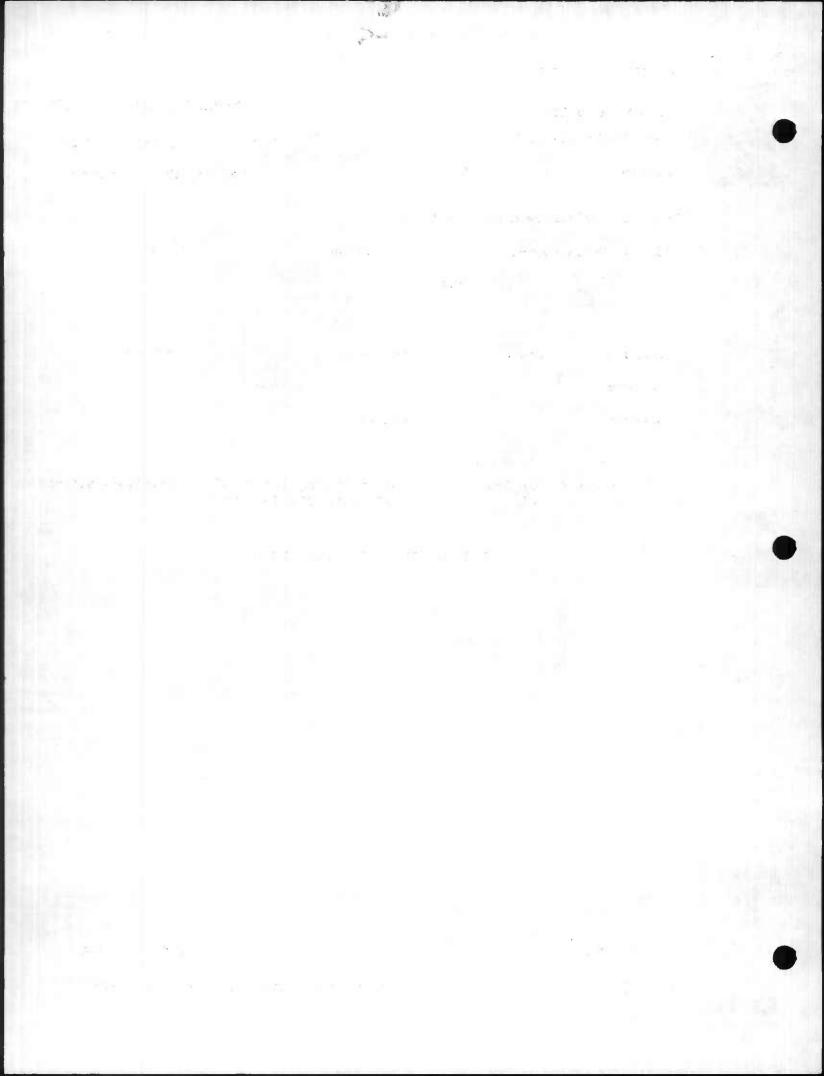
B. Sports

29c, Licanse number

OCME

29d. Date signed (Month, Day, Year)

MARCH 15, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 0.00 NAKKINGTON LEE 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hours Min. Nov. 9, 1936 N/A 7. Age (In yrs. last birthday) if Under 1 Year 9. Birthplece (State or Foreign 5. Social Security Number 6 Sex 1 M 2 XF Months Deys Mary and 214-38-8259 Usual Residence of Deceden 10c. City. Town or Location 10d Inside City Limits 10e Stete 10h Counts 1 Yes 2 No Md. Anne Arundel Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 21225 315 Fourteenth Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 □ Widowed 4 □ Divorcad 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Orthopedic College (1-4or 5+) Elementary/Secondary (0-12) 10th Medical Transscriptionist Associates 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Hartline Alice Walton Kenneth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Edward H. Narrington, Jr (Husband) 315 Fourteenth AvenueBalto., Md. 21225 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 D Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 4/3/99 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensetevin E. Ecker Mccuiry-Polyfiak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest shock, or heert feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Finel -6 YRS END STAGE RENAL FAILURE disease or condition resulting in death) RACTURE LEFT Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last ISCHEMIC CARDIOMYO Due to (or es e consequence of 5-6 415 CARDIAC ARRYTHMIA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 00 1 Yes 3 Probably 4 Unknown OSTEO GENESIS 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy BONE FRACTURES, CHRONIC 1 ☐ Yes 2 2 10 2 No 1 Tyes 25. Wes case referred to medice 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Examiner

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Manyland nent of Health and Mental Hygiene. Intel if item 27 is marked other than "natural", or items 23s or 28s-f show this if item 27 is marked other than "natural", or other traumate event, in a Medical Exertine man be notified at my or other traumate event, in a Medical Exertine man be notified at

Baltimore, Maryland 21215-0020

physician and the bunal-transit signed by the at Id be detached for

Examiner Physician/Medical 2q Completed Be Certification: To funeral

The law requires that the death certificate be executed Records, P.O. Box 68760 s certificete has t director, page 2 s Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

1 Yes 2 No 27. Manner of Deeth

2□ Accident

4 - Homicide

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one)

State Registrar

edicai

land 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) · Arguillauo Mb 31. Date filed (Month, Day, Yar)

Investigetion

6 Could not be determined

3001 32. Registrar's Signature

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

6. HANOVER ST. BALT. MD 21225

Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner stated.

29c. License number

D28988

1 Yes 2 No

281. Location (Street and Number or Rurel Route Number, City or Town, State)

MARCH

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

To the Hospital of within 24 hours at To the Funeral D completely filled

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Pages 1 and 2 should be nant of Health and Mental

Department of Health important: If Item 27 Is any injury or other tra

Examiner

physician and the burial-transit

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The law requires that the death certificate be execu

or Attending Physician:

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death.

To the Hospital or Attend within 24 hours after deat To the Funeral Director;

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Deat 2. Date of Death Month Day 1999 31, MARCH 5:45 PM. 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death APT 620
7. Age (In yrs. last birthday) ST. E. PRESTON 5. Social Security Number 217-38-748 6. Sex If Under 1 Year 8. Date of Birth 10 M 20 F Months Days Hours Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Marvland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2 on 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 SNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14 Race American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify 3 ☐ Widowed 4 ☑ Divorced ericar 7110 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
/ life. PQ NOT use setired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 OX 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maide 86 Herman 50 Informant's Name/Relationship (Type, Print) | Friend 19b. Mailing Address (Street and Number reene anice Method ot Disposition 20b. Place of Disposition (Name of cometery) crematory or other place; 20c. 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensee 22. Name end Address of Facility 22 North Ave 0/15/15 that the disease, or complication that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the first failing. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) a Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? mellitus 1 Yes 2 No 3 Probably ▼ Unknown DIABETES Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? INSPECTION 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) edical Certification: To YYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signatur and title of Cartifier TOW

5 1999

O.C.M.E.

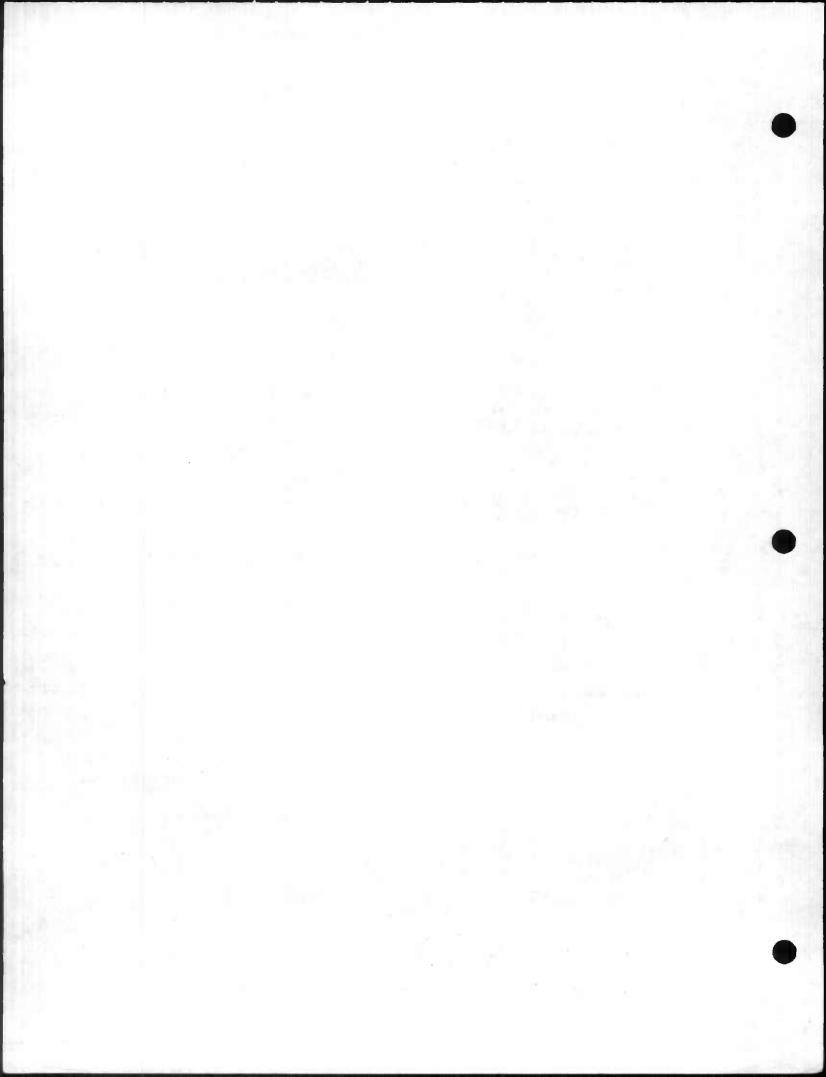
APRIL 01, 1999

JOSEPH PESTANER M.D 31. Date tiled (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

Depera

State Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death BONNIE METCALF APRIL 3, 1999 10:55 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 6007 Bauman Dr. Elkridge Howard If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Deys 1 M 2 F Months 219 40 8593 56 March 22,1943 Maryland Usuel Residence of Decedent 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits Maryland Howard Elkridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6007 Bauman Dr. 21075 United States Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Defense / College (1-4or 5+) Elementery/Secondary (0-12) Machinist Technology 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) William Fromm Jean M. Brashears 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7 Second Ave. S., Ferndale, MD Kelly Cashen / Daughter 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burlal 2X Cremation 3 Removal from State Green Mount Crematory 4/5/99 4 Donation 5 Other (Specify) Baltimore, MD 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. but Dannam 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Tyes 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined

physician and s the burial-transit Box 68760 US8 P.O. certificate of Vital we Hospital or Attending P. n. 24 hours after death.

The Funeral Director: After the felled in by the funeral Division

Physician

/Medical

Examiner

Funeral

Director

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Physician

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edical Certification: To

Baltimore, Maryland 21215-0020

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Funeral

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traumatic event, the Medical Examiner must be notified at

Records,

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DHMH 16 Rev 6/95

State Registrar

completely

To the F within 2

31. Dete filed (Month, Dey, Year)

3 Suicide

4 Homicide

(Check only one)

29b. Signeture and title of certifier

NIMMAGADDA 32. Registrar's Signature 5 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 300

Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

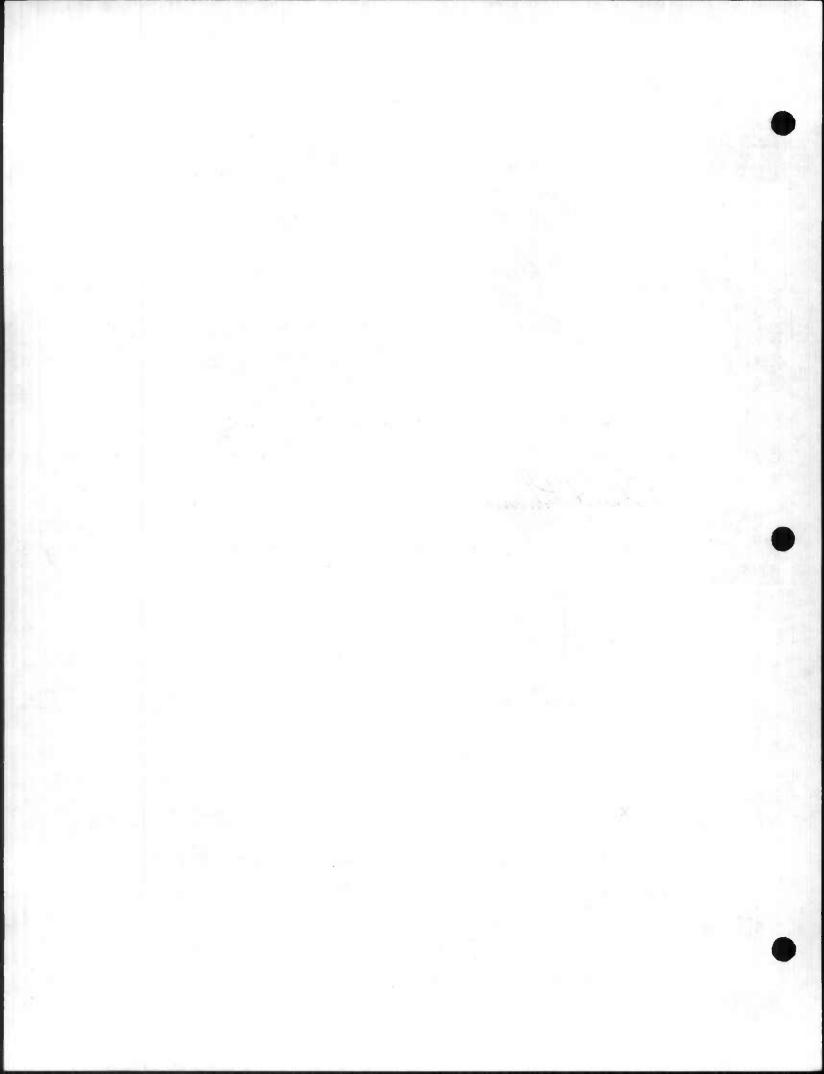
29c. License number

D39041

S. Hanover

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) Month 3:30 AM HARRY E. MARTIN APRIL 1999 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KOAD GLEN BURNIE QUEENS ANNEARUNDEL | Months | Days | Hours | Min. | Jan. 21,1918 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 81 Yrs. 217 10 2881 Pennsylvania Usual Rasidence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Insida City Limits t ☐ Yas %TNo Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7945 Oueens Road 21061 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whila, alc. 1 ☐ Yes 2 QNo If Yas, Giva Year or Dates: t ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Machinist Paint Manufacturing 17. Fathar's Nama (First, Middle, Last) t 8. Mother's Nama (First, Middle, Maiden Sumame) Henry Martin Nannie Mace t9a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Holmes / Daughter 7945 Queens Road, Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Crestlawn Memorial Park 4/2/99 Marriottsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD Xaturai 21286 23a. Partt. Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laading to immediata causa. Enlar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No t ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 21 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding 1 Yes 2 No

Physician/Medical Examine ettending physicien and for use as the burlei-transit that the deeth cartificate be executed Box 68760, USA AS P.O. Records. þ The lew requires Completed page 2 s certificate of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; Be edical Certification: To Division

Physician

/Medical

Examiner

Funeral

Director

"netural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be flied within 72 hours after of Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural, or hen eny injury or other traumatic event, the Medical Examinations."

Physician /Medical

Examiner

Saltimore, Maryland 21215-0020

Director

Funeral

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25. Was case referred to medical 1 Yes 27. Manner of Death t Natural 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide telescent telescent of the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier

29b. Signatura and titla of certifier

29d. Data signed Month Day, Year) 29c. License number

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

5 1999

7575 TLEN BURNE MD

HOPRA 31. Data filed (Month, Day, Year)

32. Registrar's Signature

State

- DHMH 16 Ray 6/95

MARKET BE PRAKEN

CANCEL LIFE L COMM.

Samuelines Park mess

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle | ast) 2. Deta of Deeth **Physician** 1999 Pearl E Murphy 2140 march /Medical 4a Fecliity Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Johns Hopkins Bayview Medical Center Baltimore City If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Sacurity Numbar 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M 2⊠ F Months Days Yrs. **Director** 215-07-9306 June 13, 1903 Maryland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Dundalk** Maryland Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1 846 Oakleigh Beach Road 21222 United States Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 2 should be filled within 72 hours after nand Mantal Hygieha. Is marked other than "naturel", or ite 1 Yes 2 No if Yes, Giva Yeer or Detes: 1 Never Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify: Specify: White òq 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturing 4 years 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) William Erdman Annie Nichols 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 Is m any Injury or other traum page. Mrs. Dorothy A. Hulbert Daughter 7516 Lang Street Baltimore, Maryland 21224

20e. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place)

20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/29/ 1999 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical J'epsis Examiner Due to (or es e consequence of): Examiner Almentia attending physician and for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): requires that the death certificate be execu Renal Failure Physician/Medical the Due to (or es e consequence of): 98 1 Failure to thrive esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24e. Wes en eutopsy performad? 24b. Were autopsy findings evelleble prior to Completed completion of causa of death? page 2 s certificate has 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No OL 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28d. Describe how Injury occurred 27. Manner of Deel 28b. Time of 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dey Year) 1 Neturel 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. Funeral Director: A Investigetion 2 Accident 6 Could not be determined 3 Suicida 28e. Piece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifian within 24 hor To the Fune completely fi edicai (Check only one) the 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. Licanse number 97010 Cauac March 26, 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

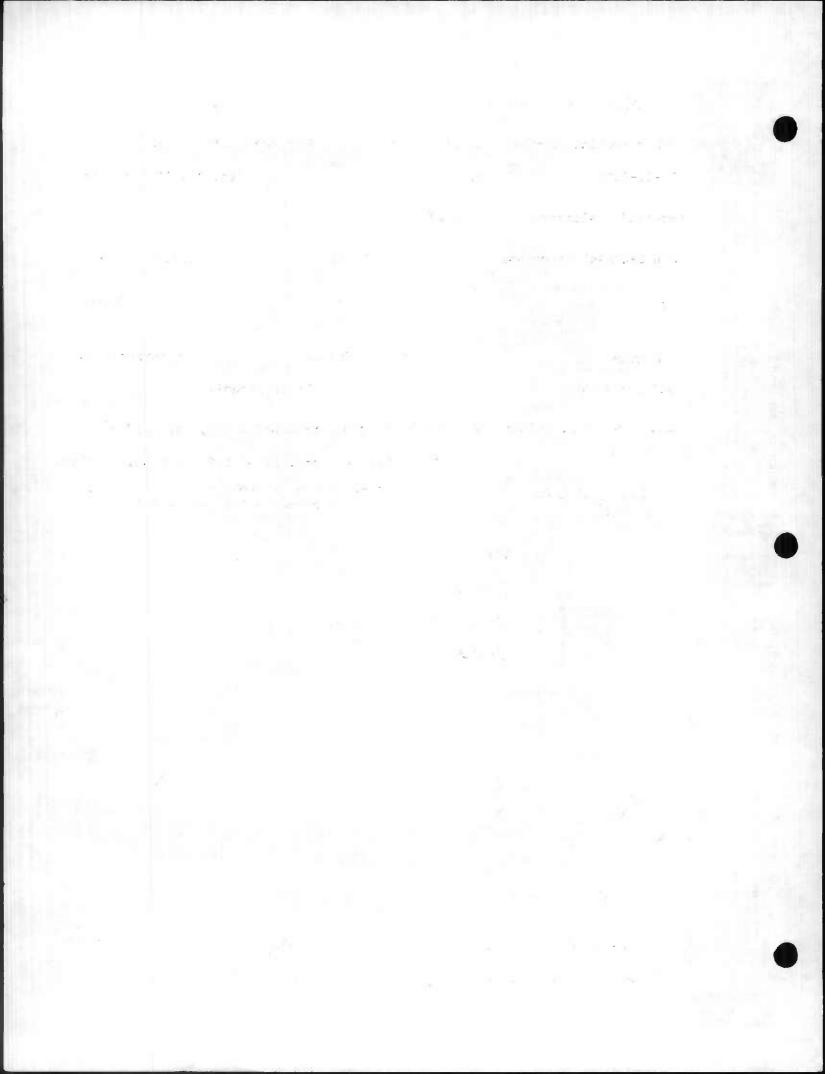
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32. Registrar's Signetura

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Dr. Sandra Chendra

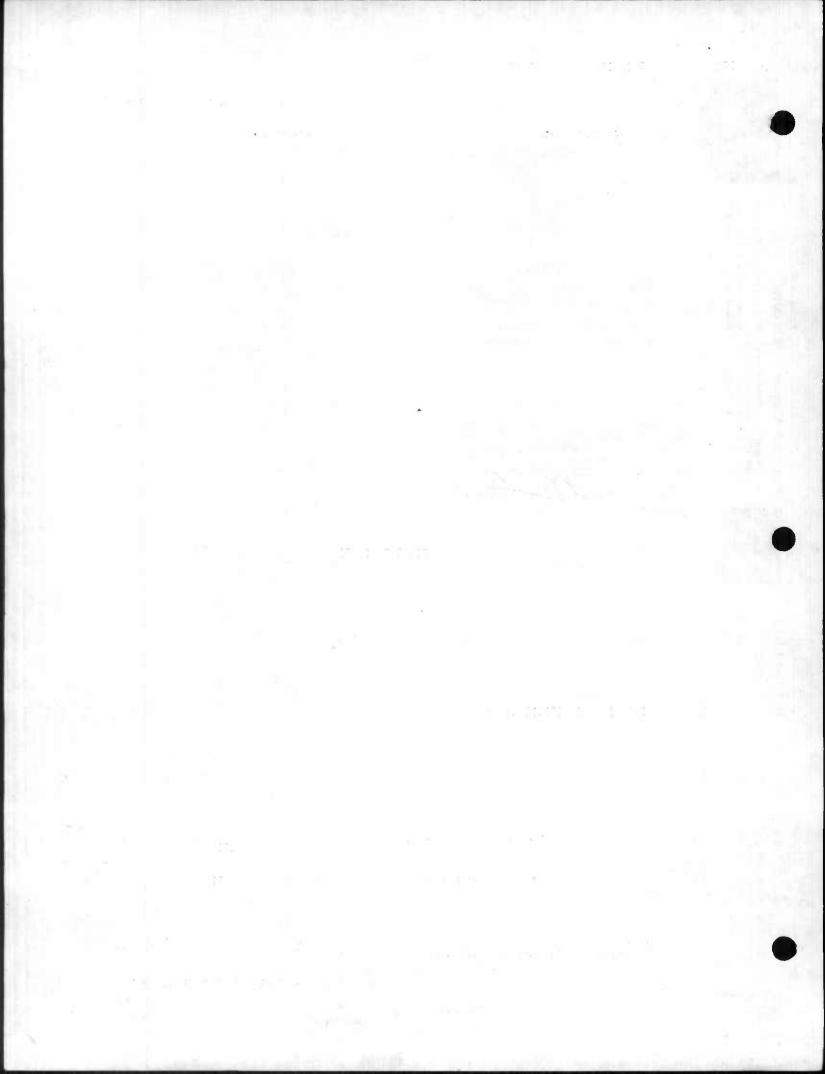


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	Mr. Tyrone Smith	/Brother					Baltimore			C+-+-			
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	4 □ Donation 5 □ Other (Special Signeture) of Funeral Service Lice		Mount	Zion C		ss of Fecility	1999	Baltim	ore, N	AD .			
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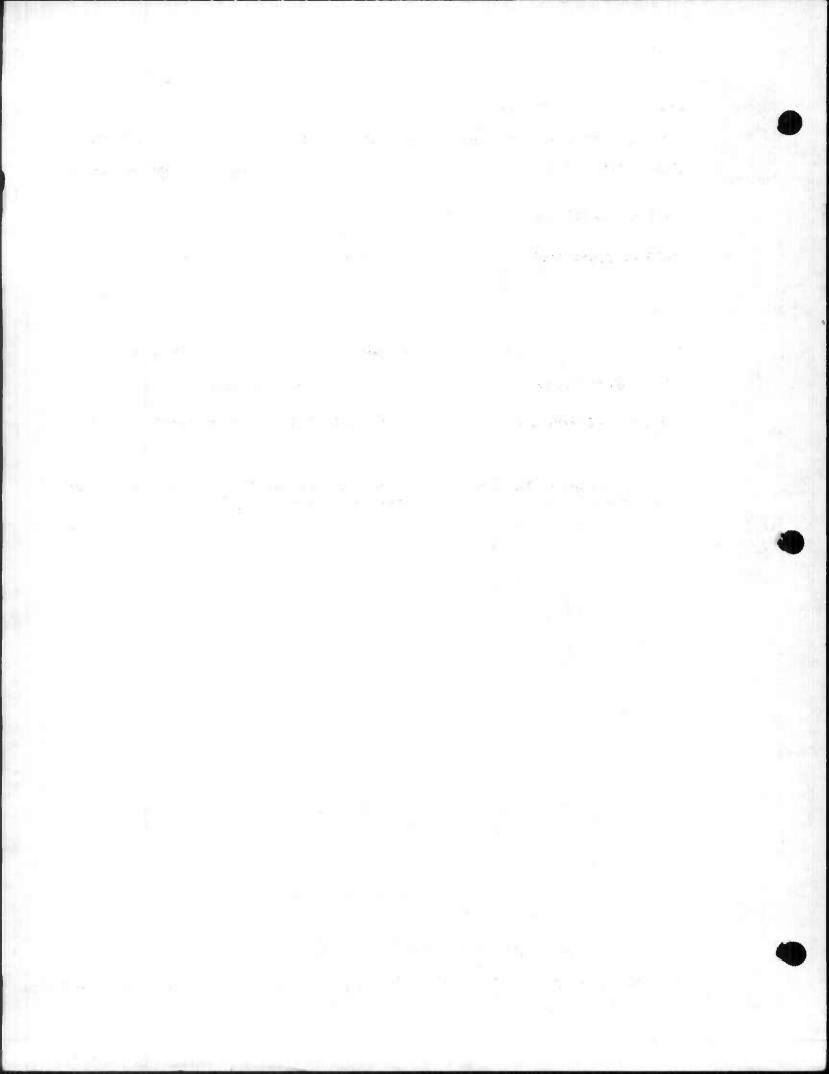
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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, Last)	of Death	2. Dete of		No.		3. Time of De
Physic		John William McCleary		Month		Day 25	Yeer 1999	3:50 A.I
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-f show find at		Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location						
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tygiene. ther than "natural", or items 23a or 28a-f shownt, the Medical Examine: must be notified at Completed by Funeral Director	Sire	10e. Street end Number 10f. Zip Cod	le		10g.	Citizen of V	Whet Coun	try?
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	þ	11. Marital Status 1 □ Never Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 ☒ No If Yes, Giva Year or Dates: 13. Was Decedent of If Yes, specify C		(Specify Yes or erto Rican, etc.)	No-		e - Americ ck, White, o	
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merk metic	10	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Str.				or Town	State Zin	Codel
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Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

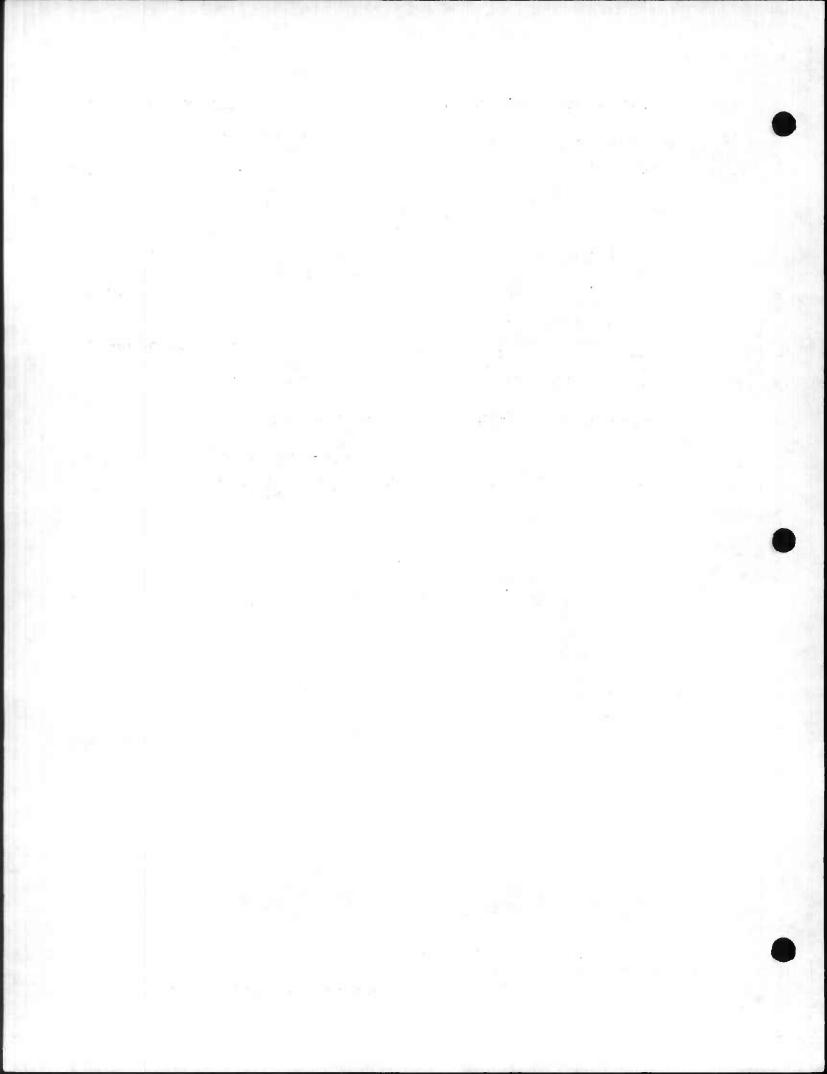
Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

CORT WASHINGTON HOSPITAL Cotal Security Number 6. Sex 15-34-8033 1 XM 2 F 59 Yrs. 59 Yrs. 6. Sex Months Days al Residence of Decedent State 10b. County 10c. City, Town or Location Baltimore Street and Number 10f. Zip Code 2122 Street and Number 10f. Zip Code 2122 Warital Status 12 Wes Decedent Ever in U.S. Armed Forces? 1 Xes, specify Cubar 1 Yes, Give Year or Dates: 15. Decedent's Education Will Yes, Give Year or Dates: 16a. Decedent's Usual Occupa (Give kind of work done diffe. Do NOT use retired) 12 College (1-4or 5+) 2 Controller	spanic Origin? (Sn., Mexican, Puerli Specify: Ition Uning most of work 18. Mother's Ner Dolores and Number or Rue Baltir Baltir Olyniak ort Ave.	SHINGTON 8. Data of Bir (Month, De Dec. 3) Specify Yes or Noto Rican, etc.) Trking me (First, Middle Wachte Wa	29, 199 h 4c. County PRING PRI	year 9 1 of Deeth CE GEOR 9. Birthplace Country) Maryl 10d. In 1 What Country? 2e - American Inck, White, etc. y: White alershi ne) Stete, Zip Cod City or Town, 3 rnie, M	(Stete or Fore and notice City Limited City	
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Manner of Death Sea. Date of Injury 28b. Time of Injury 28c. Inj	et (? Yes 2 No	28d. Describe	28d. Describe how injury occurred			
3 Suicide 4 Could not be determined 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (City or To	Street end Numb wn, State)	ber or Rural Ro	ute Number,	
Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time (Check only one) 2 [XMedical Examiner: On the basis of examination and/or investigation, in my op and manner steled.						
Signature and title of certifier 29c. License	number		29d. Date signe	ed (Month, Dey,	Year)	
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Venus J. Chutim OCME			MAKCH .	30, 1999	2	
lame and address of person who completed cause of death (Item 23a) (Type, Print)						

State Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dev Month **Physician** 3.00 pm 3/ 99 4c. County of Deat x ker 03 31 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Itimore
24 Hrs. 8. Dete of Birth HOSPIT

7. Age (In yrs. last birthdey) our H Under 6. Sex 5. Sociel Security Number **Funeral** Deys Months 218-28-113 Hours 1 M 2 F Director Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f shor traumatic avent, the Medical Examiner must be notified at 1 Yes 2 □ No altimore Funeral Directo Marviand 10g. Citizen of Whet Country? 12 Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiena.
wit: If Hean 27 Is marked other than "natural", or Itama 23 ary or other traumatic avent, fire Heoles Experiment many or other traumatic avent, fire Heoles Experiment man Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Merifei Stafus Yes 2 2 1 No 1 Never Merried 2 Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Black Specify: þ 3 Widowed 4 Divorced Year or Dates Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) eamst 0 18. Mother's Neme, (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) 19b. Malling Address (Street end Number or Rurel Route Number Stete, Zip Code) Informent's Neme/Relationship ethod of Disposition 20b. Plece of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removel from Stafe permit. Page Department of Important: If any Injury or once. 4 Donetion 5 Dother (Specify) 22 Name end Address of Fecility
JOSEPH
2222 W. Ror 21. Signatore of Funerel Service Dcensee a WiNorth Enter the disease, or complication what, or heer failure. List only one cause on caused the deeth. Do not Approximete intervel Between Onset end Death **Physician** /Medical immediate Ceuse (Fine) diseese or condition resulting in death) Examiner Examiner physician and s the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): 80 usa ò signed by tha a 23b. Did tobacco use contribute to the cause of death? Pert A Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed s certificate has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: director 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1 ☐ Yes 2 ER/Outpetienf patient th s funeral 27. Menner of Death 28a. Date of 28c. Injury ef Work? 28d. Describe how injury occurred 28b. Time of Date of injury (Month, Dey Year) 5 Pending investigation After 1 Valaturei n 24 hours after death.

• Funeral Director: Aft
bletaly filled in by the fur 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ō Hospital The certifying Physician: To the best of my knowledge, deeth occurred et the time, dafe end plece, and due to the cause(s) end menner es steted.

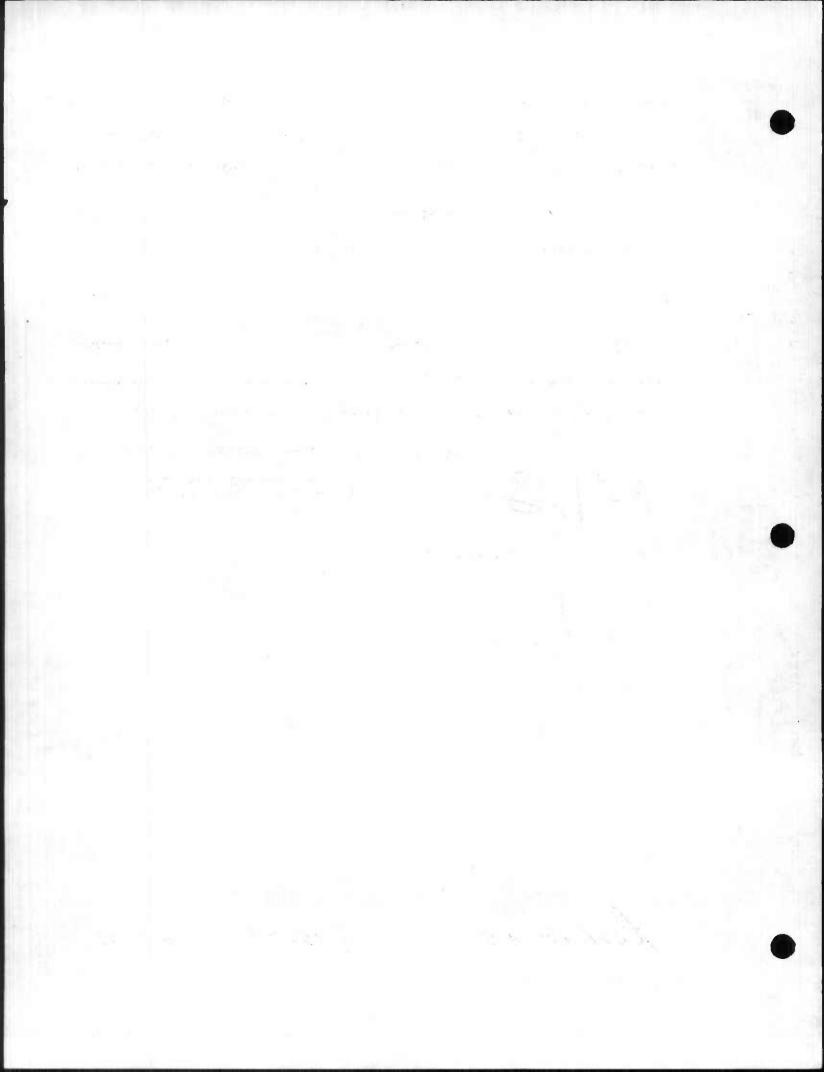
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner stated. 29a. Certifier edical completaly (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end fitte of certified Neme end eddress of person ted cause of deeth (item 3e) (Type, Prin 31. Dete filed (Month, Day, Yeer, 32. Registrer's Signeture State 5 1999 Registrar **DHMH 16 Rev 6/95**

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	Examiner	4a Facility Nema (If not institution, given	re street and number)			4b. City, Town, or I	ocation of Deat	h 4c. County	of Death			
		Stella Maris H	ospice			Timonium		Balt	imore			
	Funeral Director	5. Social Security Number 6. \$ 219-01-9858	Sex 7. Aga (In)	yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da July 0	th Year) 4 1921	9. Birthple County Mary			
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		5820 Clarks Hil	1		2121	.0		Tog. Citizentoi	. Citizen of What Country? USA			
020			12. Was Decedant Evar Armed Forces? 1 Yas 2 No If Yas, Giva Yaar or Datas:	9f	Vas Decedent of Yas, specify Cul ☐ Yes 2 1 No	Hispanic Origin? (Span, Mexican, Puerl Specify:	pecify Yes or No o Rican, atc.)		ce - America ck, Whita, a y: Whit	tc.		
Maryland 21215-0020		15. Decedant's E (Specify only highest gra Elementary/Secondary (0-12)		(Give I	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)		vorking		Businass/Industry			
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		ysician; To the best of my niner: On the basis of axan end manner stated.									
	To the Complex Complex Med	29b. Signeture and title of certifier	mn		29c. Lieur	1550	4	29d. Data signe	ed (Month, D			
		30. Name and address of person who	complated causa of death			ny Dona	Timor	111m 34	ID 210	003		

OHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Meer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

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al	Decedent's Name (First, Middle, Last))	^		2	Date of Death		3. Time of Death		
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	Facility Name (If not institution, give :	sireel and number)			own, or Loca		4c. County of	1		
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	13-94-3873		/ / 113.		F	PRIL 6,	19.79	MARYLAND		
	suat Residence of Decedent la. State 10b. County	100	City, Town or Location					10d. Inside City Limits		
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M	ARYLAND N/	A	10	ALTIMO	RE	CITY		VOC 162 5 114		
10	e. Street and Number		10f. 2	Zip Code		/100	g. Citizen of Wha	at Country?		
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11	. Maritet Status	12. Was Decedent Ever in	U,S. 13. Was Dec	cedent of Hispanic O	rigin? (Specif	y Yes or No-		American Indian,		
	1. Never Married 2 Married	Armed Forces? 1 ☐ Yes 2.25 No		pecify Cuban, Mexico		an, etc.)		White, etc.		
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify	y:		Specify:	BLACK		
_	15. Decedent's Edu	cation	16a. Decedent's Us	sual Occupation		16	6b. Kind of Busin			
	(Specify only highest grade	(Give kind of I	work done during mo	st of working						
	Elementary/Secondary (0-12)	/	COOK		A	10000	11 12 Page			
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-	UODEPH	DE	LILLY	100	ROTE	TY		MAKKEK		
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0	OROTHU PARKER	(MOTHER)	619 ALL	ENDALE	STREE	T. BAL	TIHORE.	MD. 21229 ty or Town, State		
200	a. Method of Disposition		Ptace of Disposition (A	lame of		Date 20	C. Location - Ci	ty or Town, State		
	1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State		0		11 00	Y 4-7 . 10.	Line Line		
21				AR (EME	11-0VU4-	06-77 C	ATONS	SILLE, MARYLA		
1	21. Signature of Funeral Service Librarysee 22. Name and Address of Facility RowN JR. FUNERAL Home									
	2140 N. FULTON ATE, BALTIMORE, MD. 2121									
23	 Part1. Enter the disease, or compli shock, or heart feilure. List only or 	cations that caused the de	eath. Do not enter the m	ode of dying, such a	s cardiac or r			Approximate Interval Between		
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lm	nmediate Cause (Finat	M. H	1 6-					1		
disease or condition resulting in death) a										
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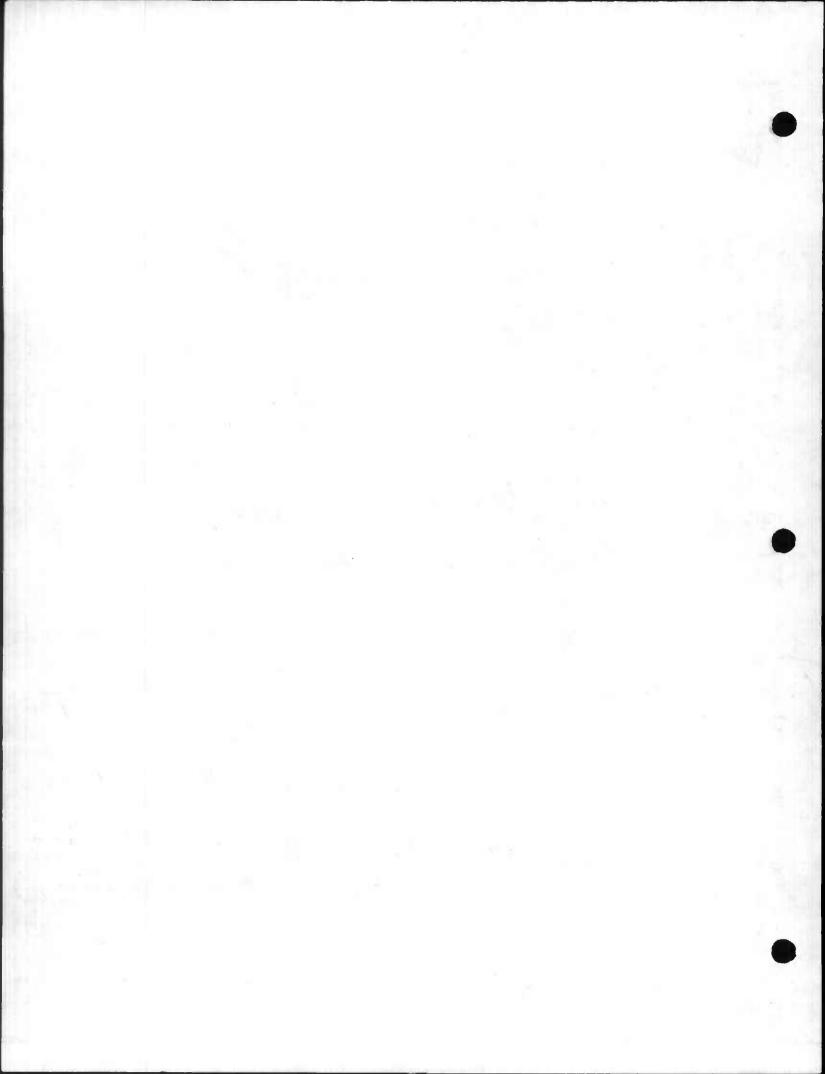
State Registrar

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DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

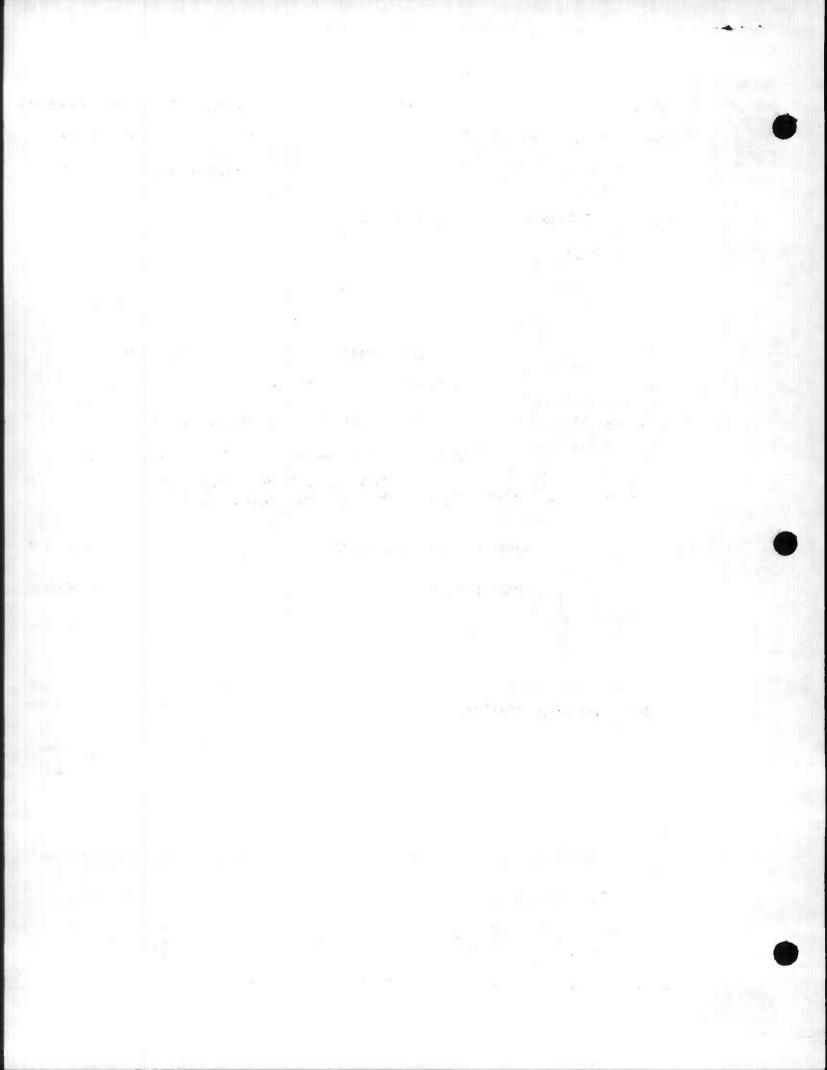
111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 9

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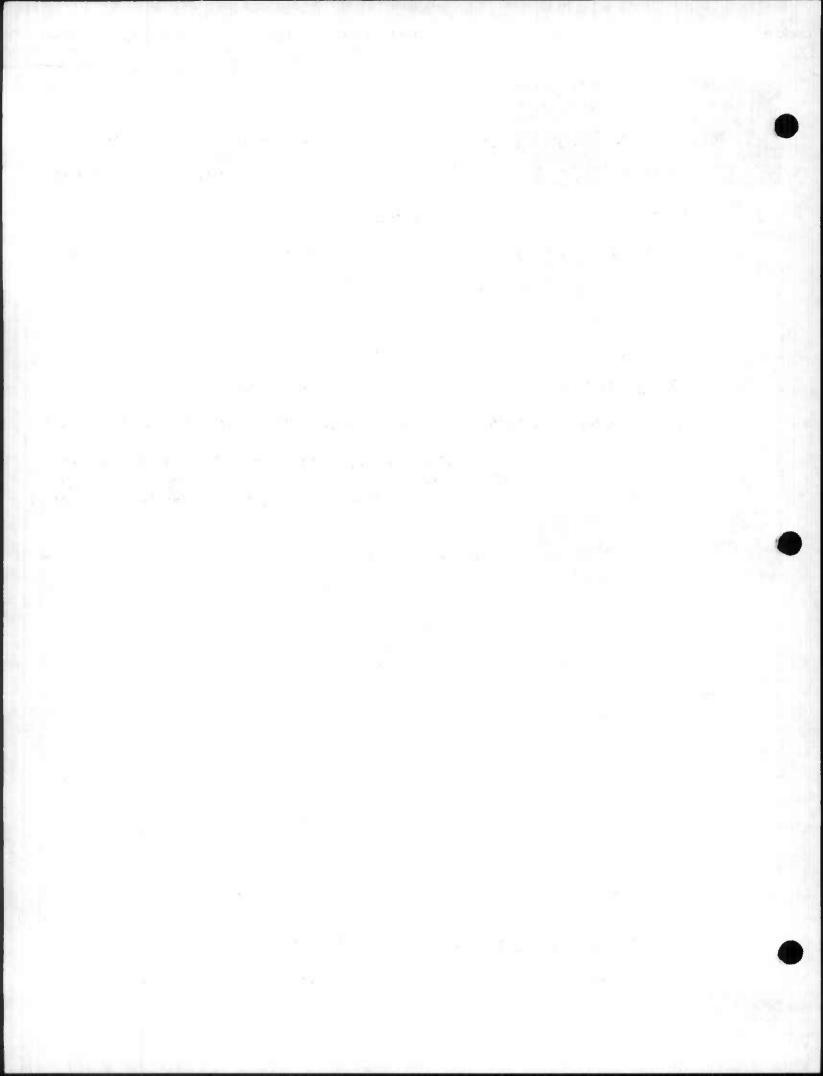
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		10e. Streef and Number				10f. Zip Code			10g. Citizen of	Whet Cou	intry?		
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	1 🖾 Burial 2	Cramation 3 P			o. Placa of Disposition (Name of cematary, cramafory or other placa)					. Location - City or Town, Stata			
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	21. Signature of F	uneral Service Licere	(D) P		Ri	uck Tow	son Fune	eral Home	, Inc.				
		me 27	TORY		105	50 York	Rd. Tov	vson, Md.	21204				
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3	Port II Other elec	ificent conditions cor	atributing to death by	uf not resulting	a in the und	odvina course o	iven in Bod I	23h Die	tobacco usa c	ontribute	to the cause of de		
Physician/Medical Examiner		Part II. Other eignificant conditions contributing to death but not resulting							Did tobacco use contributa to the cause of de 1				
y P	CONGE	ESTIVE HEAD	RT FALLURI	E				_	100 225110	•	, , , , , , , , , , , , , , , , , , ,		
Be Completed by								24a. We	s en eutopsy formad?	24b. V	Vara eutopsy findir vailabla prior to		
200								_ per	iormad r	0	completion of cause of daeth?		
E								10	Yas 28 No		☐Yes 2 No		
0	25. Was case refe	erred to medical					26 Place of I	Daath (Check only					
0	examiner?		lospital:	nt 2□ER/	Outpetient	3□ DOA O	thos:	g Home 5 ☐ Ras		thar (Spec	oifv)		
n: To	4.4	7. Mannar of Death 28e. Date of Injury 28b. Time of 28c. Injury et 28c.							how injury occu		,		
atio	1 X Naturel 2 Accidant	5 Panding invastigation	(NOTALL, Da)	y (Gai)	Injury		Yes 2 No						
edical Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be detarmined	28a. Place of Injubuilding, at	ury - At homa, c. (Spacify)	farm, straa	t, factory, office	9	28f. Location City or T	(Street and Num own, State)	nber or Ru	ral Routa Number		
	29a. Cartifiar (Check only	1⊠ Certifying Phys											
8	one)		and mannar sta	ated.	anaoi iiivo.			ocarred of the time					
Σ	29b. Signatura an	d title of certifiar	-9	MA		110	nse number		29d. Date sign	ed (Month	n, Day, Year)		
	,	moll	4 don	MD		D 24	1034		3/30	19	7		
	30. Nama and add	irass of person who	plated cause of d	aath (Itam 23a	a) (Type, Pr	int)							
	TIMOTH	Y LOW. M. I	7601	OSLE	R DR	IVE, T	OWSON,	MD 212	04				
te	31. Dete filed (Mo	nth, Day, Year)	32. Registra	ar's Signeture	6	1							
rar	0	APR 5 19	99	was	D.	popor	W						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, La.	s()	Certificate of	Death	Re 2. Data of Deeth	g. No. 99	1 0 0 0	
Physician	ELEANOR	m. PETERS			Month		(ear 3:41	
/Medical			APRIL					
Examiner	4a. Facility Name (If not institution, give				b. City, Town, or Location of Deeth 4c. County of Death			
	Keswick Multi-			Baltimo			N/A	
Funeral Director	5. Sociel Sacurity Number 6. S 220-01-4548 1 Usual Residence of Decedent	ex	est birthday) If Under 1 Year Months Days	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, July 15,	1918	D. Birthplace (State of Country) Marylane	
pug *	10a. State 10b. County	10c City	, Town or Location				10d Incide Of	
eho		/A					10d. Inside Cit	
octo		A	Baltimore					
ufer death with the Ma r tems 23s or 28s-f since routed the route notified Funeral Director		10e. Street end Number 2956 Wyman Parkway 21211		21211	10	g. Citizen of Wh Unit	ed States	
or, o	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	13. Was Decedent of if Yas, specify Cut		cify Yes or No- Rican, etc.)		American indian, Whita, etc. White	
led within 72 hoi tygiane. her than *natura nt, tr. Medical	15. Decedent's Ed	ucation	16a. Decedent's Usuei Occu	pation	1	6b. Kind of Busi	nass/Industry	
Ple Ple	(Specify only highast gra	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workilled)	ng			
T the	12		0wn	Home				
tal Hys d othe event,	17. Fether's Name (First, Middle, Last)	,		18. Mother's Nama	(First, Middla, M.			
Mental Mental Mental Barked attic ev	George Brannan			Vera S	heeler			
d Mer	19e. Informant's Name/Reletionship (1	Simo Print)	19b. Mailing Address (Stree			Olar and Taxon O	7-0-1-1	
d 2 s th en 7 ia u	, ,							
l end leaith m 27 ther tr	James W. Brannan		1 North Roll	ing koad				
Pagas nent of H nrt: If Ite iry or of	20a. Method of Disposition 1 Burial 2 Coremetion 3		ace of Disposition (Neme of metery, cremetory or othar ple	ece)	Date 2	0c. Location - Ci	ty or Town, State	
Pag nen ury	4 ☐ Donation 5 ☐ Other (Specif)	Hil	Itop Service (Corp. 4	/3/99	Towson	, Maryland	
permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If I tem 27 is marked other than any injury or other traumetic event, training once. To Be Compl	21. Signature of Funeral Sarvica Licen	Michael E. Cana	•	J. RUCK,	INC	5305 Ha Baltimo	arford Roare, MD 2	
	23e. Part1. Enter the disease, or comp shock, or heart failura. List only						Approximete	
Physician	snock, or near failura. List only	one ceuse on each line.					Interval Betw Onset end D	
/Medical	immediete Ceuse (Final	21-	05027 Faill				2 100	
Examiner	disease or condition rasulting in death)	e. KESPIR	asory faill	26			2 use	
j		· ·	as a consequence of):				3 1/2 4	
ng isit		b. BRONCHO P	ALKEOLAL CAN	2020ma			3 12 1	
ificata be executed g physician and es tha burial-transit ledical Examiner	Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or Injury	E		10 45				
E 000	Cause (Disease or Injury that Initiated events resulting in deeth) Lest	Due to (or d	es a consequenca of):					
the death cer d by the ettendin letached for use Physician/N	Part II. Other significent conditions of	entributing to death but not resul	iting in the underlying cause gi	ven in Pert I.	23b. Did tob	acco use contr	ibute to the cause o	
igned by be detac by Phy					1 Yee 2 No 3 Probably 4 Unkn			
Hospital or Attending Physicien: The law requires their the death cent 5 Annus alert death. Furnarial pirector: After this certificata has been signed by the ettending etaly filled in by the funeral director, page 2 should be detached for use of the funeral director. Grant Filled in by the funeral director. Grant Filled in by the funeral director.					24a. Was en performa		24b. Wara autopsy fi available prior to completion of ce of death?	
The page					1 ☐ Yes	2 No	1 ☐ Yes 2 🔀	
entific ector, Be	25. Was case referred to medical	(Check only one)					
hysic his ce il direc	exeminer? 1 Yes 2 No	Hospital: 1 ☐ inpatient 2 ☐ E	R/Outpetient 3 DOA Ot	her: 4 Nursing Hon	ne 5 Rasiden	ce 6 Other	(Specify)	
erai	27. Mannar of Death		28b. Time of 28c. Inju		8d. Describe hov			
th. Afte	1 Natural 5 ☐ Pending 2 ☐ Accident investigation			rk?]Yes 2 □ No				
or Atten ster dea Director in by the	3 Suicide 4 Homlcide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route City or Town, Stete)							
To the Hospital or Attending P within 24 hours after death. To the Eureral Director: After the completaly filled in by the funeral Medical Certification:	29a. Certifier 17 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my know lner: On the basis of exemination and manner stated.	ledge, deeth occurred et the ti on and/or investigation, in my e	me, dete end plece, e oplnion, death occurre	and due to the ceu ad et the time, det	rse(s) end menn e end placa, and	er es stated. d due to the cause(s)	
To the within 2 To the comple	29b. Signature end the of certifier	Note mi	\	12399		ATRIL Z	Month, Dey, Year)	
	30. Neme and address of person who o	completed cause of deeth (Item :	23a) (Type, Print) 24, 22 7 20 4. ure G. Span	40th St	3AzTim	elt, m)	21211	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signatu	ure /					
Registrar	APR 51	999	D. Spor	Kel				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Dete of Daeth 3 Time of Death Month 4 Dey 3 1 9999 9:52am Violet Grace Ross 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Daath Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 9. Birthpiece (State or Foreign Country) Devs Months 1□ M 2∯ F Hours Yrs. England 217-28-0620 77 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? 21061 USA 1 Baylor Road Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Was Decedent Ever in U.S. 14. Rece - American Indien, Black, White, etc. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No if Yes, Give Specify: White 1 ☐ Yes 2 No Specify: f Yes, Give Yeer or Detes: 3 € Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel County Elementery/Secondery (0-12) College (1-4or 5+) School System Cafeteria Helper 12 17. Fethar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Emma Coles William G. Holtom 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 939 Fallridge Way Gambrills MD 21054 David Ross (son) 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Chesapeake Cremation Center 4 ☐ Donetion 5 ☐ Other (Spacify) Stevensville, MD 22. Name end Address of Fecility Singleton Funeral Home, P.A. 1 Second Ave. S.W. Glen Burnie MD. 21061 implications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, my ona cause on each lina. Immediate Clusa (Final GLIOBLASTOMA MULTIFORME year diseese or condition resulting in deeth) Due to (or es e consequenca of): Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Wara eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 No 1 □ Yes 2 □ No

Physiclan /Medical Examiner

The law requires that the death certificate be axecuted

P.O. Box 68760,

Records,

of Vital

Division

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10e Stete

MD

Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mantal Hygene. Important: If fem 27 is marked other than "natural", or items 23s any injury or other tranmetic avants.

Baltimore, Maryland 21215-0020

the Marylend

Examiner physician end is the burief-trans Physician/Medicai should be det þ Completed page 2 Be Certification: To

is certificata h

filled in by

edicai

Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certifica

To the Hospital
within 24 hours e
To the Funeral C

Sequentially list conditions, if eny, leading to Immediate cause. Enter Undarlying Ceusa (Disease or injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpetlent | 3 | DOA Other: A Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and menner stated. 29c. License number

29b. Signature end title of certifier

MILMARL

4 Homicide

29d. Date signed (Month, Dey, Year)

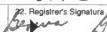
Location (Street end Number or Rural Route Number, City or Town, Stete)

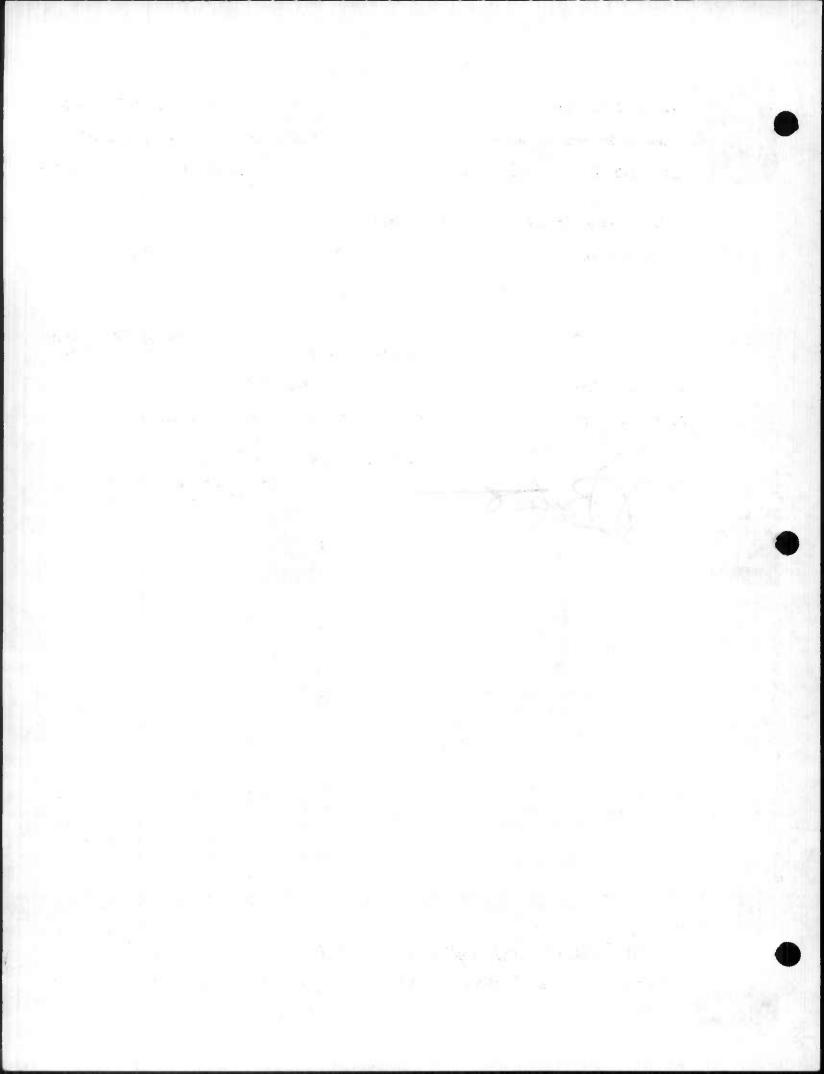
Musician MERP 30. Nama and eddrass of person who complated causa of dagh (Itam 23a) (Type, Print)

PURTEI JHBUMC 4940 FAITERY RVa BALTIMOR Md 21224

State Registrar

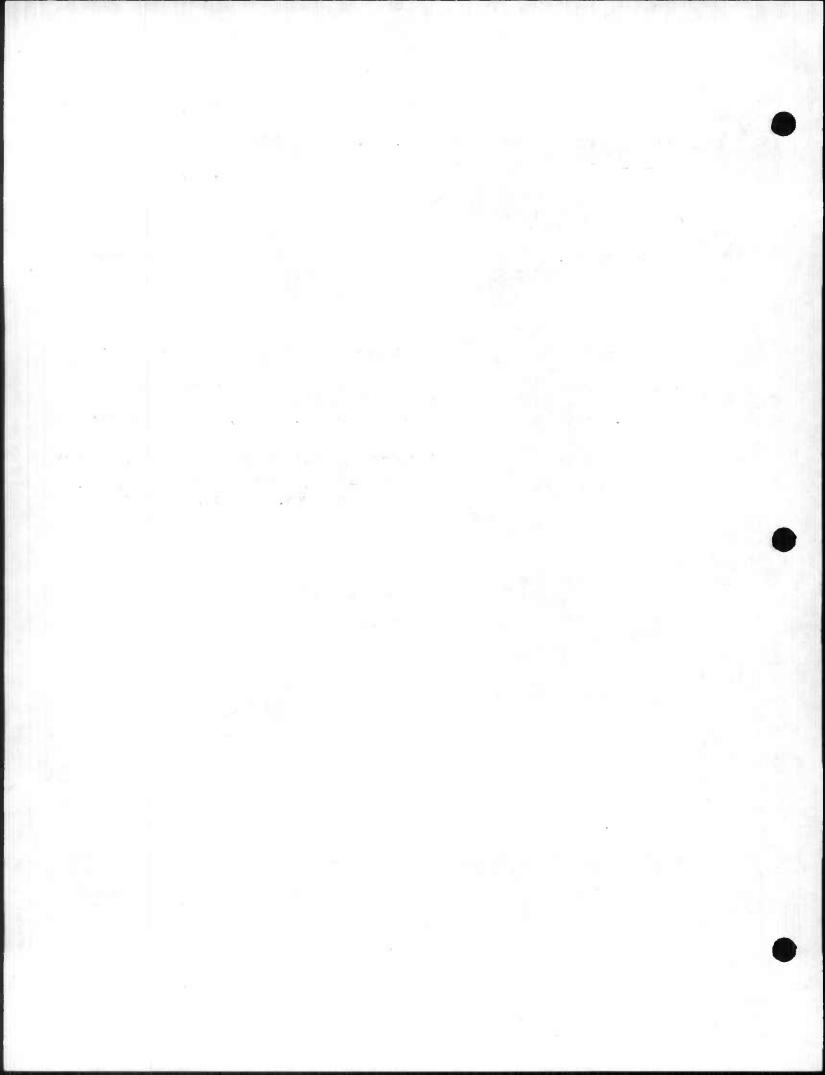
31. Data filed (Month, Day, Year) APR 05 1999





Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

	Certificate of Death	1	leg. No. 99	10809				
ician	1. Decedent's Name (First, Middle, Last) Jo Anna Regulski	2. Date of Dea Month April	Day Ye	3. Time of Deat ar 3:55 A				
dical niner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or	-						
al or	Genesis Heritage Meridan Eldercare Ctr. Dundal. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs 219-32-7063 1 M 2 F 61 Yrs. Months Days Hours Min.	s. 8. Date of Birth		9. Birthplaca (State or For Country) Maryland				
	Usual Residence of Decedent		7=00,					
_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin 1 ☐ Yes 2 ☐				
Director	Maryland Baltimore Es	sex						
Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What	t Country?				
al, or items 23e or 28e-1 sho Examiner ment be notified at by Funeral Director	341 Oberle Ave. 21221		United					
by Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Specify Cuban, Mexican, Puerl If Yes, Give Year or Dates:	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. White				
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years 15. Decedent's Usual Occupation (Give kind of work done during most	rking	16b. Kind of Busine					
Š		me (First, Middle,	Maiden Sumame)	Cai				
To Be		nda Ryka						
-	-	al Route Number, City or Town, State, Zip Code)						
	Terry M. Scordo/Son 341 Oberle Ave. Es	sex, Maryland 21221						
	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City	or Town, Stete				
	1 LTBurial 2 LiCremation 3 LiHemoval from State	5/99	Dundalk.	Maryland				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda—Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
for use as the burial-transit clary. Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. CON CESTIVE HEART FAIL Due to (or as a consequence of): CHROMIC RENAL FAILUM Due to (or as a consequence of): CHROMIC RENAL FAILUM Due to (or as a consequence of): DIABETES MELLITUS Due to (or es e consequence of): SEPSIS	26						
Physician/M	Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of c						
		1 Yee 2 No 3 Probably 4						
Completed by		24a. Was a perfor	an autopsy 2. med?	4b. Were eutopsy finding evailable prior to completion of caus of death?				
000		1 🗆 Y	es 20No	1 Yes 2 No				
Be (25. Was case referred to medical examiner?	ath (Check only o	ne)					
2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 Resid	lence 6 Other (Specify)				
Certification:	27. Manner Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury et Work? M 1 Yes 2 No							
Certif	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	n, State)	Io.a. House Nomber				
edical	29a. Certifler (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ■ Medical Examiner: On the basis of examiners and the control of the basis of ex	a, and due to the d irred at the time, o	cause(s) and manne date and placa, end	or as stated. due to the cause(s)				
ž	29b. Signeture and title of cartifier 29c. License number		29d. Date signed (N	fonth, Day, Year)				
	Carriedo la CIALLE MD D27188		4/21	99				
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Say volu 18 Teelke 2 Market Place	Buttie	re MD	21222				
tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature							
rar	APR 05 1999 Deven by Account							



SWOPE

the Maryland

99-1911-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

VINCENTA	

Item#20c perFH G770 4/5/99 EW

4a Facility Name (If not institution, give street and number)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

/Medica Examine	
LAdillile	

1. Decedent's Name (First, Middle, Last) Vincenta

2. Date of Death 3. Time of Death Month 1999 APRIL 4:14P.M.

1605 CLARKSON STREET 5. Social Security Number 220-07-0996

7. Age (In yrs. last birthday) 1□M 21XF 78

If Under 1 Year If Under 24 Hrs. Days Hours Months Aug.

N/A 8. Date of Birth (Month, Day, Year) Aug. 29, 1920 9. Birthplace (State or Foreign Maryland

Funeral Director

28a-f

ras 23a or

e filed within 72 hours after di if Hygiene. other than "natural", or flem rent, the Medical Examiner r

permit. Pages 1 and 2 should be 1 Department of Health and Mental I important: if Item 27 is marked of any injury or other traumatic eve

Physician /Medical

Examiner

physicien end the burial-transit

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signed by the a

page 2 s

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After

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within 24 hours after deet To the Funeral Director:

Hospital

Fo the

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filled in by

that the death certificate be executed

The law requires

Box 68760,

P.O.

Records,

of Vital Physician:

Division or Attending Physician/Medical Examine

þ

Completed

Be

Certification: To

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

10a. State 10b. County Maryland N/A

Usual Residence of Decedent

10c. City. Town or Location Baltimore

Swope

10d. Inside City Limits 1 Yes 2 No

4c. County of Death

10e. Street and Number

1605 Clarkson Street

10f. Zip Code 21230 10g. Citizen of What Country? U.S.a

Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc. specify: White

1 ☐ Never Married 2 ☐ Merried 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed)

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Detes:

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 No Specify:

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12th Grade

Filing Clerk

Hospital

17. Fether's Neme (First, Middle, Last)

Frank Sa₁a Alice Gertrude Fuchs

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informent's Name/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 S. Hanover Street Balto, MD 21230

4b. City, Town, or Location of Death

BALTIMORE

Charles Swope 3rd Son

20b. Place of Disposition (Name of cematary, crematory or other place)

20c. Location - City or Town, State

20e. Method of Disposition PBurial 2 ☐ Cremation 3 ☐ Removal from State

Glen Haven Memorial Park 4/5/99

Glen Burnie Geen Burnie Maryland

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses medica

22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue Balto., MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

tmmediate Cause (Finel disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseese or Injury that initiated events rasulting in deeth) Last

Due to (or as a consequence of)

Dua to (or as a consequence of):

Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

INSPECTION 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 M No

25. Was case referred to medical examiner? 1X Yes 2 No

1 X Neturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 \ Homicide

27. Manner of Death 5 Pending investigation

1 Inpatient 28a. Dete of Injury (Month, Day Year)

Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

one) 29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) APRIL 2,1999

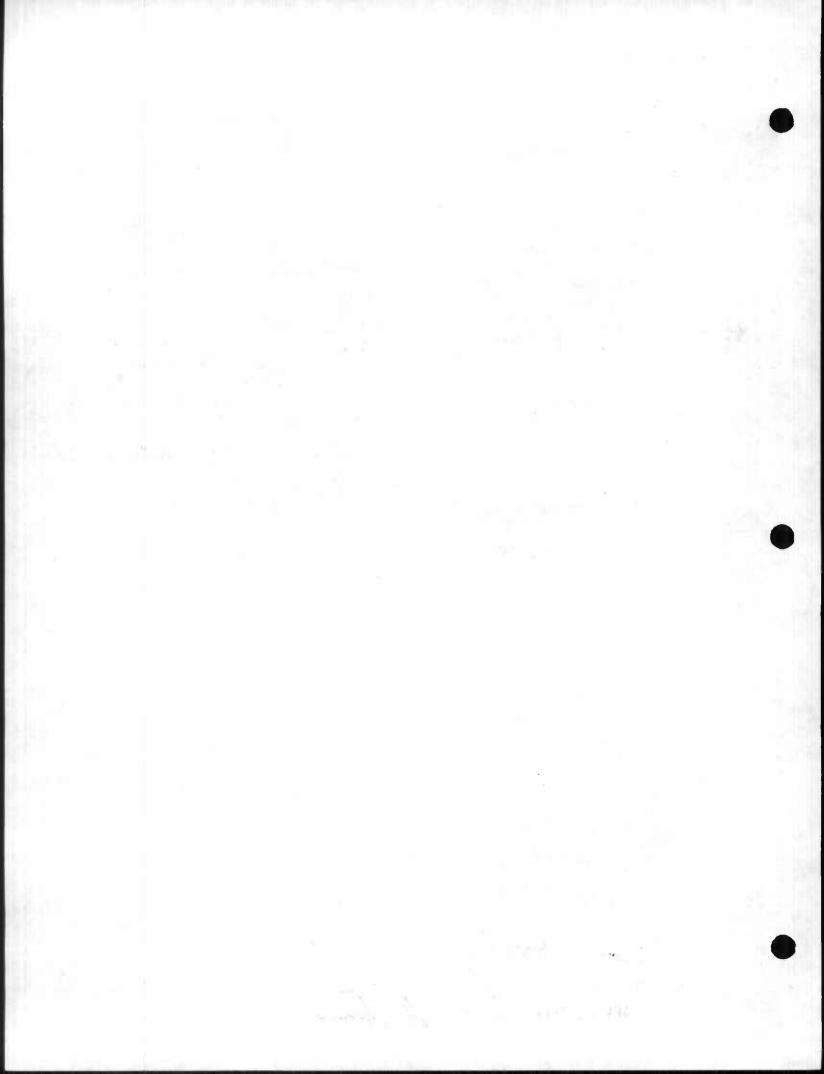
d address of person who completed cause of death (Item 23a) (Type, Print)

Hospitel:

J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) APR 0 5 1999 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ALBERT SIEGERT 4 99 5:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BERLIN If Under 24 Hrs. SANDRIDGE ROAD WORCESTER If Under 1 Yeer 8. Date of Birth (Month, Day, Year) 2-11-28 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Days 1 M 2 □ F Months Hours Yrs. 220-22-168 Usual Residence of Dece Director MARYLAND the Meryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exemples must be notified at once. 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 □ No Director MD. WORCESTER BERLIN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3 SANDRIDGE ROAD Funeral 21811 12. Was Decedent Ever in U,S.
Armed Forces?
1 ⊠ Yes 2 □ No 194
If Yes, Give
Year or Dates: 194 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1947altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced 1949 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE 9 OPERATION MANAGER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname) Be **EDWARD** SIEGERT SOPHIE REITERER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY SIEGERT (Wife) SANDRIDGE ROAD BERLIN, Mp. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/6/99 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications the Vorused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACCINOMA Examiner (Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): 80 by the attending i 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been signal 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yes 2 No Hospital or Attending Physician: director, 25. Was case refarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 70 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours efter To the Funeral Direc completely filled in by 4 Homicide efter Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

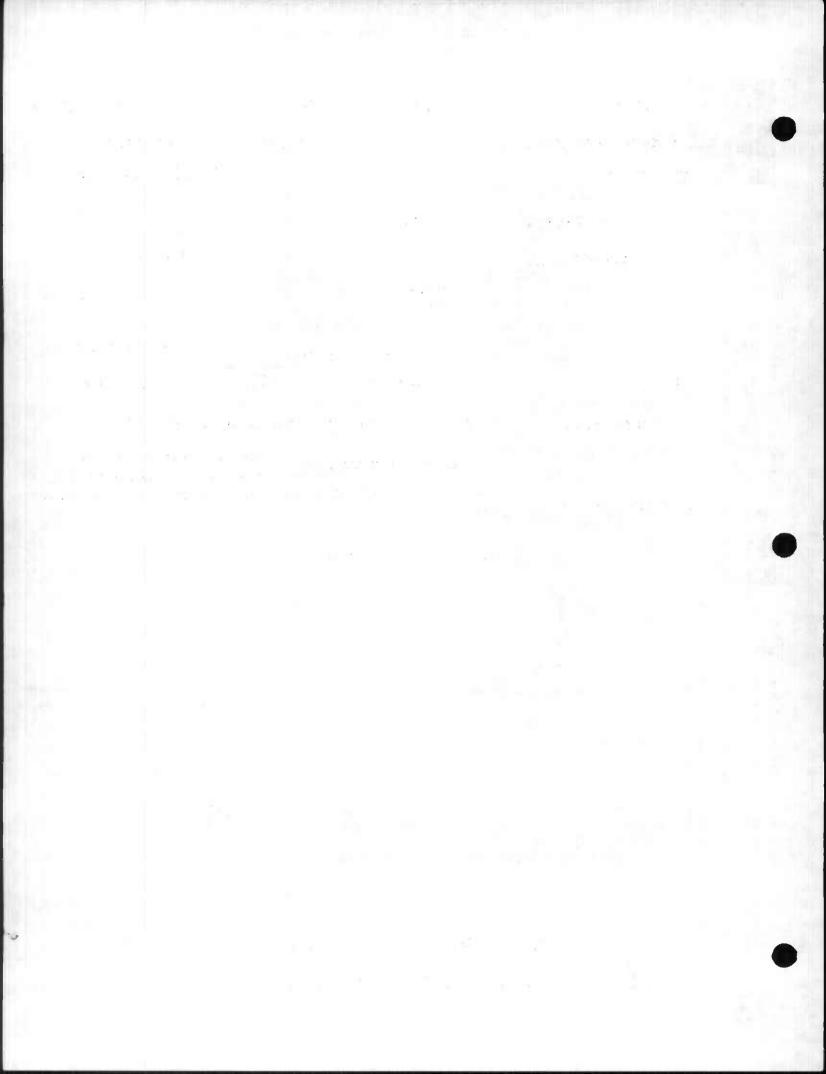
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) 30. Name end address of MD Un, T 19314 -32, Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

n 5 1999



1 Decedent's Neme (First Middle Last) 2. Dete of Deeth Month **Physician** April 2, Robert Tilghman Strudwick /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner Greater Baltimore Medical Center Towson If Under 24 Hrs. 6. Sex 11 M 2 ☐ F If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Deys Hours Min. 75 Yrs 230-12-3031 **Director** Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 28a-f show r is marked other than "natural", or itama 23a or 28a-f shoi traumatic event, the Mobical Experience mant be notified at Directo MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12 E. Eager Street 21202 Funeral 12. Wes Decedent Ever in U,S. Amped Forces? 1 △ Yes 2 ☐ No If Yes, Give Yeer or Detes: 44 1 -75 1 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married "natural", or 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorcad Strudwick Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Insurance Executive permit. Pages 1 and 2 should be filed Depertment of Health and Mentel Hygi-Important: If itam 27 is marked other any Injury or other traumatic event, II 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Unknown 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Barry Strudwick/ Son 215 Goodale Road Baltimore, MD 21212 20b. Plece of Disposition (Neme of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Buriel 2 Cremetion 3 Removel from Stete April 3, Baltimore Washington 4 Donetion 5 Other (Specify) 1999 Crematory 22. Name end Address of Fecility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael Flagle 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner

Approximete Intervel Between Onset and Deeth

3. Time of Death

12:30 am

Birthpiece (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

NC

1999

4c. County of Deeth

Baltimore

USA

14. Reca - American Indien, Bleck, White, etc.

Insurance

Specify: White

Laurel, MD

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events

attending physician and for use as the bunal-transit cartificete be executed Box 68760. 80 The law requires that the death signed by the a peen has cartificate Division of Vital Physician: this funaral After t I or Attending Patter death. n 24 hours after death.

Ne Funeral Director: Af bletaly filled in by the fu

þ

Completed

Be

2

Certification:

Medical

Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

Bilanial

Compostur

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

Due to (or es e consequenca of):

Due to (or es e consequence of):

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

25. Wes case referred to medical exeminer? 1 ☐ Yes 25 No 27. Menner of Deeth

Hospitel: DETropatient 2 ER/Outpatient 3 DOA 28b. Time of

28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes

(505 N. (horros Sty Suit 203 Bulting, up 21204)

28d. Describe how Injury occurred

1 ☐ Yes 2 No

Naturel 2 Accident 3 ☐ Sulcide 4 Homicide

resulting in death) Lest

5 Pending investigation 6 ☐ Could not be 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Procumenia

Paulin

heart

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of cartifier

29c. License number

29d. Date signed (Month, Dey, Year)

MD

D0057955

4/3/99

Cynthia L. Midlanum up

31. Dete filed (Month, Dey, Year)

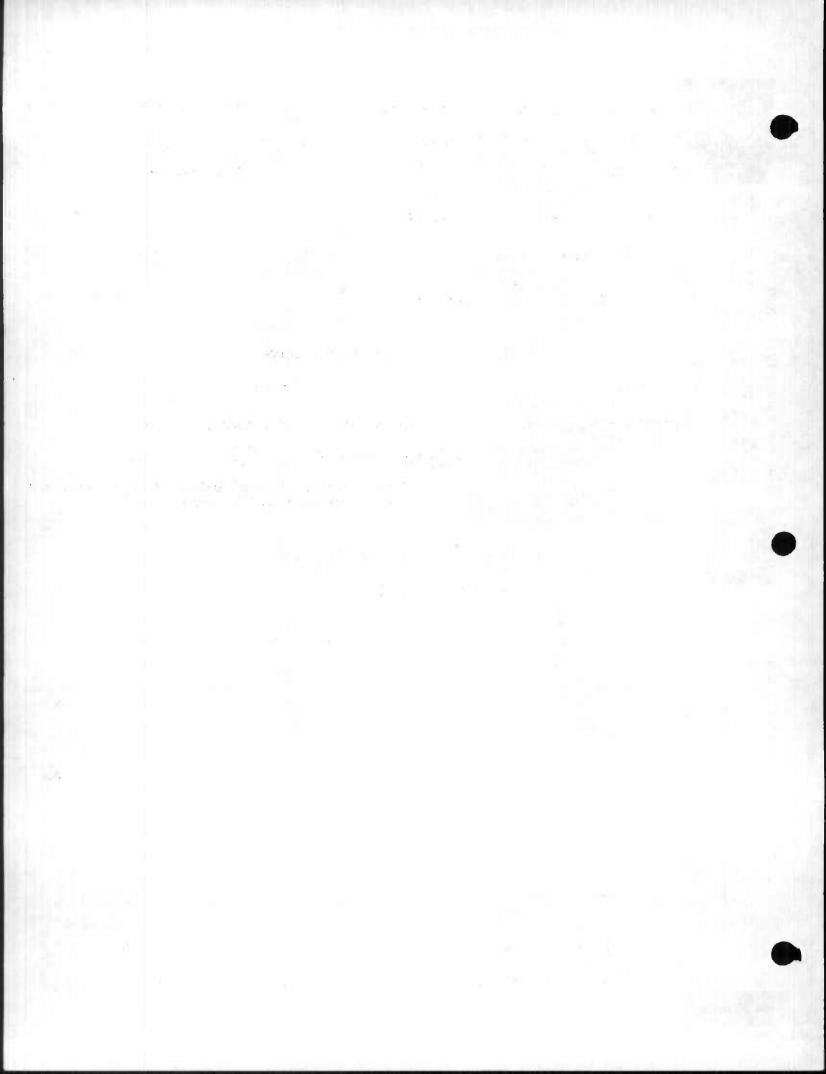
32. Registrer's Signeture

State Registra

DHMH 16 Rev 6/95

within 2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Irene P. Snead PIT MARCH 30 /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Mercy Hospital Baltimore n/a If Under 1 Yaar | if Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min. 1 M 2 219-28-3266 67 Yrs. Director Nov. 16, 1931 Md. Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at Md. n/a Baltimore 1KX as 2 □ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 1 3716 Bartwood Road 21215 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Stetus 1 ☐ Never Marriad 2 ☐ Marriad 1 ☐ Yes 2☐ No If Yas, Give Yaar or Datas: 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Baltimore d 2 should be filed within the and Mental Hygiena. 7 Is marked other than " Elamantery/Secondary (0-12) Collega (1-4or 5+) School System Teacher/ Housewife 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Sterling Phillips Helen Phillips 19e. Informant's Nama/Ralationship (Type, Print) husband 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) any injury or other any in Colidge Snead 3716 Bartwood Road Baltimore, Md. 21215 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Qunal 2 Cramatum 4 Donation 5 Other /S Ramoval from Stata April 2 Baltimore, Md. Woodlawn Cemetery 5 Other (Specify) 22. Nama and Addrass of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part 1. Enter the disaasa, or complication. that caused the death shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death Do not antar tha moda of dying, such as cerdiac or respiratory arrast, **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical 6 months Examiner Dua to (or as a consequanca of): Examiner certificate be executed attending physician end for use as the bunal-transit Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Disaasa or Injury that initiated evants resulting in death) Last Dua to (or as a consaquanca of): Box 68760. Physician/Medical Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Ves 2 No 3 Probably 4 Unknown 6 signed t Division of Vital Records, by 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 s Jas 2 000 1 ☐ Yas 2 ☐ No certificate 25. Was casa rafarred to medical axaminar? 26. Place of Death (Chack only ona) STEIIA MARIS AT MERCY Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSpicE 1 Yas 2 No To 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 28e. Deta of Injury (Month, Day Year) Certification: or Attending 1 Dalatural 5 Panding Invastigation s after death. 1 ☐ Yas 2 ☐ No 2 Accidant the 6 Could not be detarmined 3 Sulcida Location (Streat end Number or Rural Routa Number, City or Town, State) 28a. Pleca of Injury - At homa, ferm, street, factory, office building, atc. (Spacify) 6 4 Homicida Hospital 24 hours 29a. Certifian 🗜 Certifying Phyaician: To tha bast of my knowledga, daath occurred at tha time, data end place, end due to the ceuse(s) and manner es steted. complataly 2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted. (Check only one) To the F within 2

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State Registrar 31. Data filad (Month, Day, Yaak)

APR

29b. Signeture and title of certifian

5 1999

32. Registrar's Signature

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30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Paul Pl Baltinery

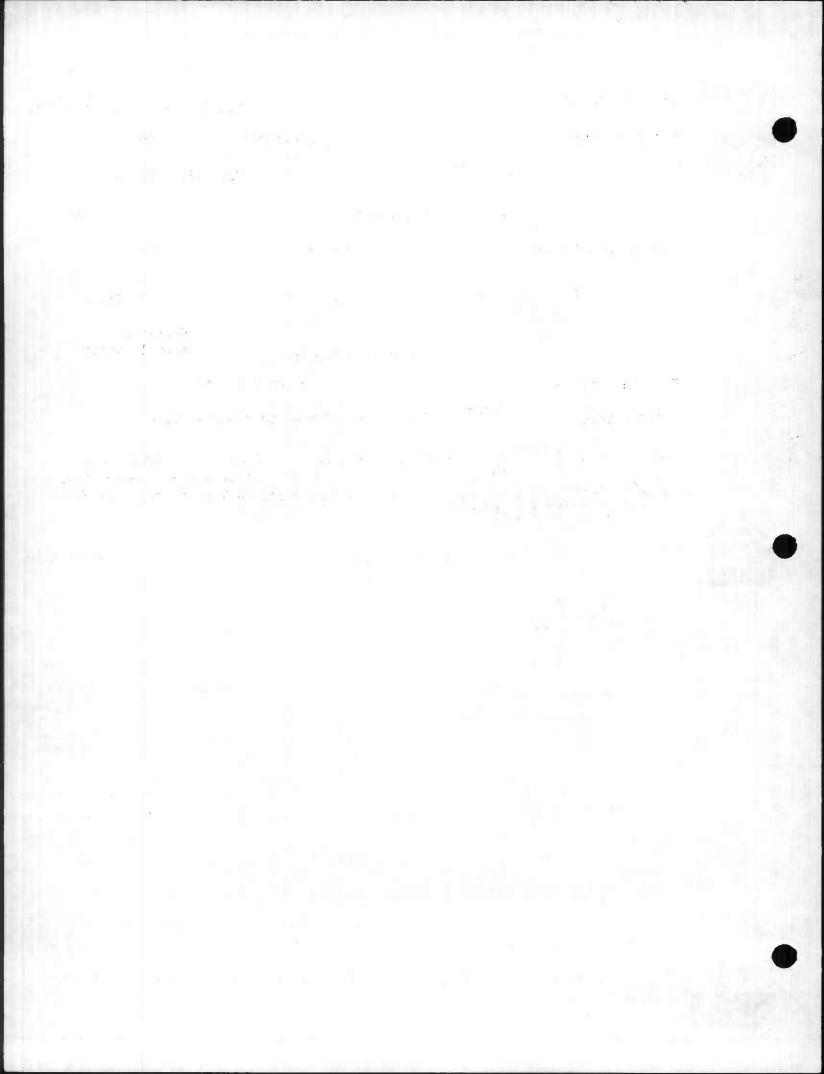
29c. Licansa number

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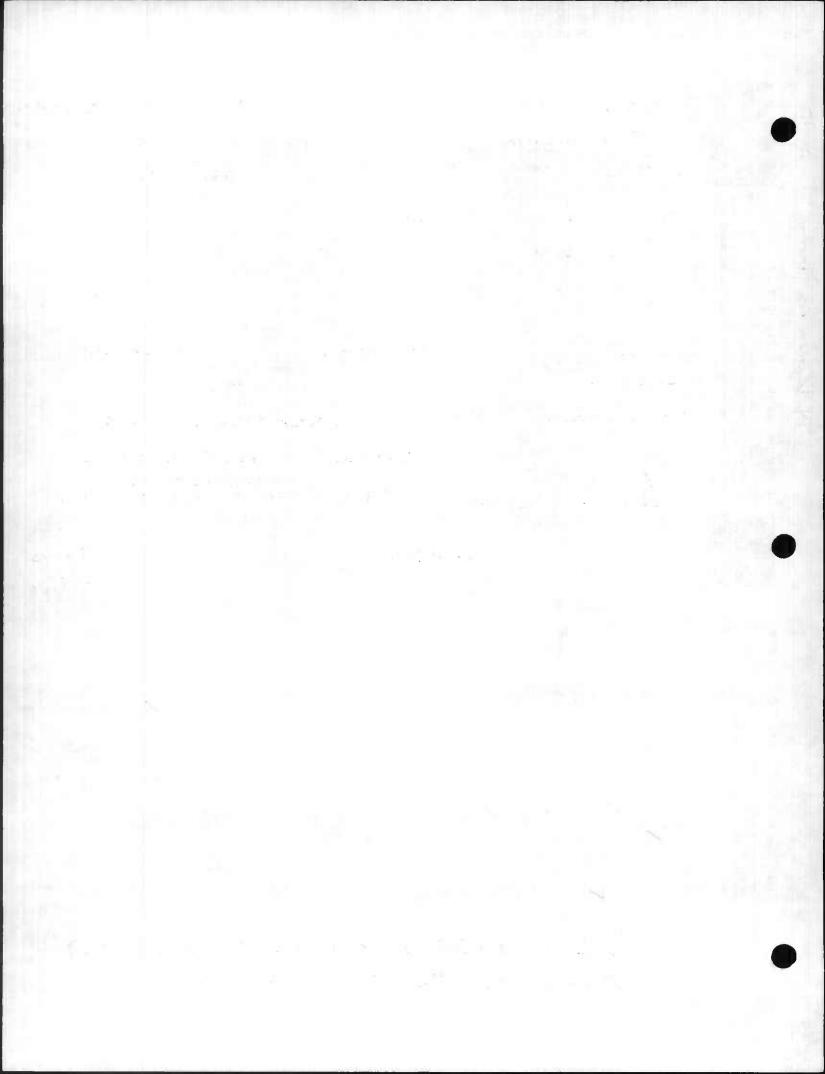
29d. Data signed (Month, Day, Year)

MARCH 30, 1999

21202



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Thomas Franklin Scott 2 03125 AM April /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Ballimore Cit Sinai Hospital n/a If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** M 2DF Months Deys 218-18-2167 75 Yrs. Director 12, 1923 Usual Residence of Decedant the Maryland 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23a or 28a-f ahow traumatic event, the Medical Examinan trausi be notified at Md. 1 yes 2 No n/a Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2728 Cylburn Avenue 21215 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Black by 3 □ dowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry A. Known al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Arab Salesman Self-Employed 5th Grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) end Mantai Samuel Scott Pauline Tibbs 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Heelth end Important: if Itam 27 ls m any injury or other traum pncs. niece Edde V. Pennington 2728 Cylburn Avenue Baltimore, Md. 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Conation 5 Other (Specify) Mt. Zion Cemetery April 6 Baltimore, Md. 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service License 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Renal Yailure **Examiner** Due to (or as e consequence of) Examiner 575 attending physician and for use as the bunal-transit The law requires that the death certificete be asscuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of). P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peen has 1 Yes 2 No 2 12 No cartificata or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending daath. 1 Yes 2 No investigation 2 Accident after daath Director: / within 24 hours after das To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Thomloide Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, and due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner stated. (Check only one) 29b. Signature at Resident physician 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print). 31. Dete filed (Month, Day, Year), 1 32. Registrar a Signature 1999 Registrar

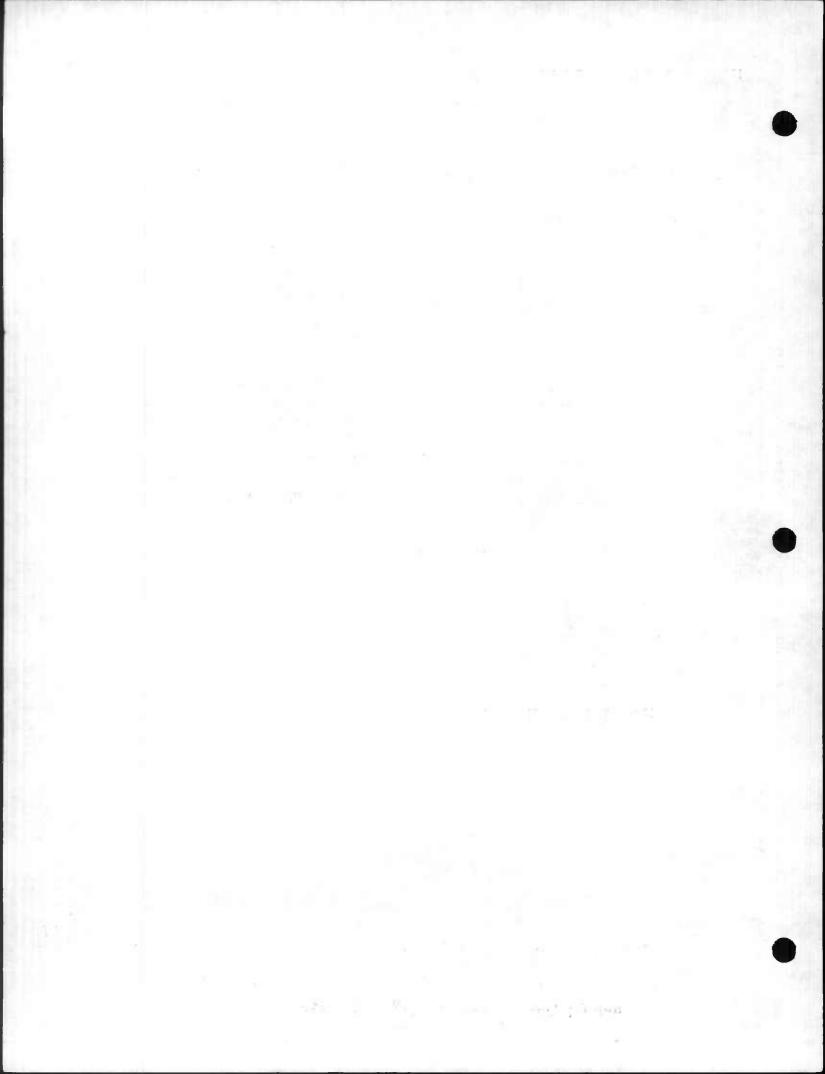


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JO	SEPH FR	ANK SCALES #23 PART I, 11, 27, P					and Mental Hy	ygiene Reg. No.		0015	
	Physician	Decedent's Name (First, Middle,	Last)				2. Dete of D	eeth 3	Year	3. Time of Death	
2	/Medical	Joseph Fran				4b. City. To	APRIL			0545 AM	
	Examiner	6223 PIONEER I					TIMORE	N/A			
	Funeral Director	5. Social Security Number 217-54-8978 Usual Residence of Decedent	. Sex 7. Ag 1⊠ M 2□ F	ge (In yrs. last birth 45 Yı	Months Day		24 Hrs. 8. Dete of B (Month, D 11 - 29 -	irth Pay, Year) 1953	Counti	ece (State or Foreign ry) yland	
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	a or 28a-f a be notified		V0		10f. Zip Code	212	1./	10g. Citizen of	whet Counti	•	
	or thems 23, unions must y Funeral	11. Meritel Status 1 Never Merried 2 Merried	Ever in U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Ori Joan, Mexicar	igin? (Specify Yes or N n, Puerto Rican, etc.)		ce - America ck, White, e	nerican Indian, hite, etc.		
Maryland 21215-0020	ygiene. ver than "netural", o it, the Medical Exam Completed by		Education	1974-1976	ecedent's Usuel Occ Sive kind of work don fe. DO NOT use retii	upation ne during mos red)	at of working	16b. Kind of B	Wi	hite _{Ustry}	
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ore,	of Ham of Bam or othe	20a. Mathod of Disposition		20b. Piece of D	isposition (Neme of cremetory or other p		Date	20c. Location	•	m, State	
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of Vital	his certifical director,	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Outp	atient 3 DOA	Mh an	of Deeth (Check only ursing Home XX Res		ner (Specify)	
On of ling Phys After this funeral di	Affer fund	27. Manner of Death 1 🖾 Naturel 5 🗆 Pending 2 🗆 Accident investigat	28a. Date of Inju (Month, Da		ne of 28c. Inj		28d. Describe	how injury occur			
5	rs after death. al Director: After tied in by the funent Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, fem c. (Specify)	, street, fectory, office	6	28f. Location City or To	(Street end Numb own, Stete)	ber or Rurel	Route Number,	
	24 hour Funer stely fill dical	29a. Certifier (Check only one)	Physician: To the best aminer: On the basis of and manner sta	examination and/	leath occurred et the or investigation, in my	time, date an opinion, dee	d place, and due to the oth occurred at the time	e cause(s) end m o, dete end place,	enner es sta and due to	ited. the cause(s)	
10 to	To the comple	296. Signature and title of certifier	who or	M		c.M.E		29d. Date signe APR]	ed (Month, D		
		30. Name and address of person who	o completed cause of d	P 111		et, Ba	altimore, M	Maryland	21201		
	State Registrar	31. Dete filed (Month, Pay, Year)	1999 32. Registr	ar's Signature	6. spor	K					

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DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month MARY SENGER 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day Year) Aug. 7, 1917 7. Age (In yrs. lest birthday) 1□M 2□F Maryland 81 Yrs Aug. 10c. City, Town or Location Baltimore Baltimore City 10g. Citizen of Whet Country? 10f. Zip Code 21229 U.S.A. 14. Reca - American Indien,

3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 3:50 PM /Medical 4e Fecility Neme (If not institution, give street end number) Examiner 601 Yale Avenue 5. Social Security Number 9. Birthpleca (State or Foreign **Funeral** 218-36-3159 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminal must be notified at 1 SYes 2 No Director Maryland 10e. Street end Number 601 Yale Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 2 should be filled within 72 hours after and Mental Hygiena. Is marked other than "natural", or its 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 0 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3€ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker Unknown Unknown 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any linjury or other traumatic event BREs. 17. Fether's Neme (First, Middle, Last) Mary Popp Max William John Senger 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Ronald Senger/son Ilnknown 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donation 5 ☑ Other (Specify) In State 22 Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street 21. Signeture of Funeral Service Licenses Joseph B. Van Sant Baltimore, Maryland 21201 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Examiner Due to (or es e consequenca of):

CORONARY ARTERY DISEASE

Due to (or es e consequence of): Examiner shysician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury HYPERTENSION the attending physician Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest MELLITIMS 38 usa 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilebie prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 0 After this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Division of Vital Records,

al or Attending P s after death. I Director: After t od in by the funera To the Hospital within 24 hours a To the Funeral C

Registrar

Medical

31. Dete filed (Month, Day, Yeer)

29b. Signeture end title of certifier

4 | Homicide

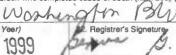
(Check only one)

29e. Certifier

0 5 1999

deller

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

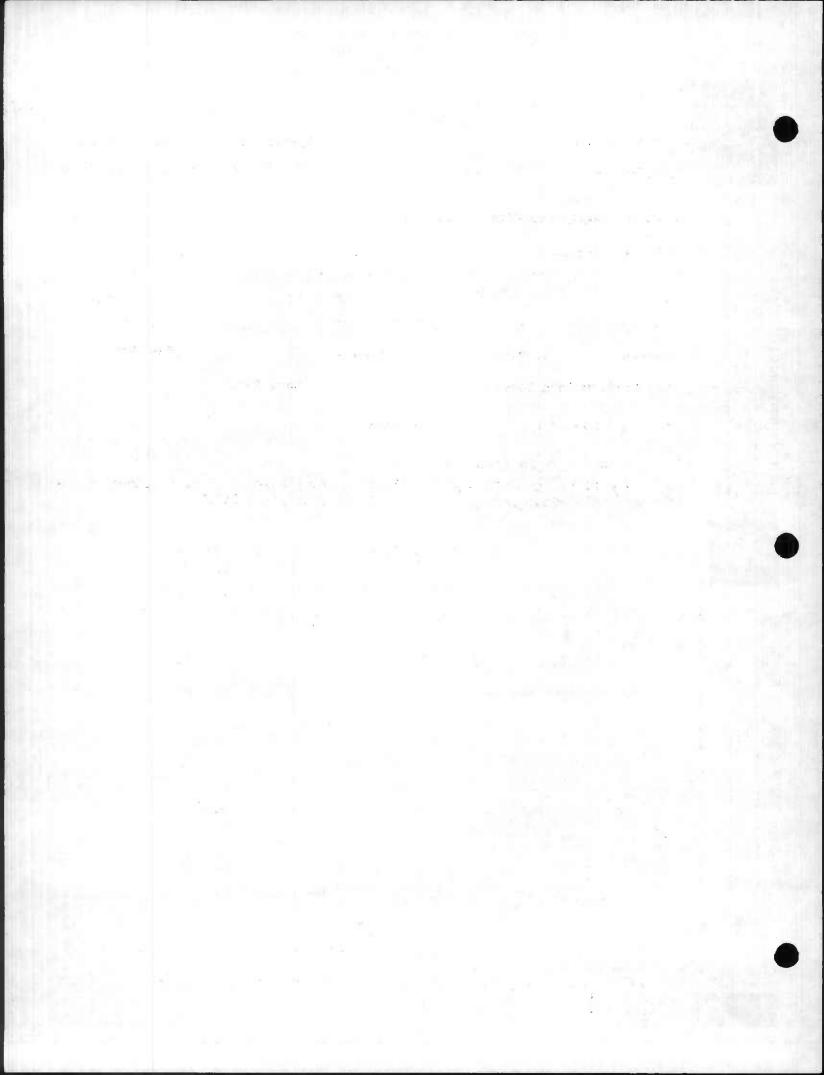


BACTIMORE, MO -

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

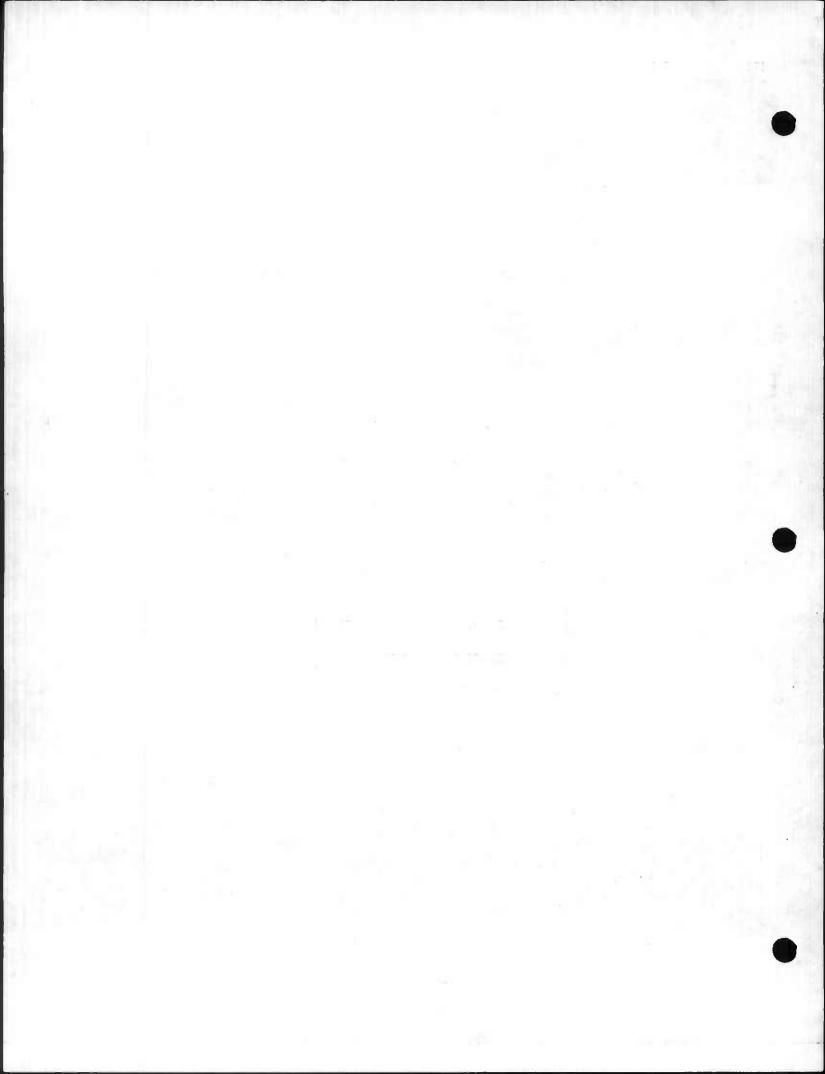
29c. License number

29d. Date signed (Month, Day, Year)



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: #23	State of Maryland / Department of Health a B PART I, 29C PER MD G770 4-5-99 WR. Certificate of Death		rgiene	10817					
Physician /Medical	Corroll Marina Tannari	2. Date of D Month	n 30 1 Yaa	3. Time of Death 23 30 pm					
Examine	4a Facility Nama (If not Institution, give street and number) 4b. City, To								
		imore	N/						
Funeral Director	234-46-4192 1XM 2 F 66 Yrs. Months Days Hours	Min. (Month, D	ay, Year) 1, 1932 We	irthplace (State or Foreign Country) st Virginia					
pu M	Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits					
the Marylen 284-f show nother an		110		1 ☐ Yes 2 DNo					
vith the Mar	10e. Street and Number 10f. Zip Code		10g. Citizen of What (Country?					
sth will	6621 Stockton Lane 20784		USA						
ind 21215-0020 be filed within 72 hours after deeth with the Marylend tal Hygiene. I other than "natural", or items 23s or 28s-f show avant, the Medical Examine ment be notified at the Completed by Finneral Director		n, Puarto Rican, atc.)	Black, Wi	narican Indian, nite, atc. White					
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121215-0020 led within 72 hours at ygiene. ovr than "natural", or it, fre Medical Exami	(Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+)	st of working	working						
nd 212 e filed with il Hyglene. other than	Meat Cutter		Grocery	Store					
		ar's Nama <i>(First, Middle</i> iriel F.]							
Maryland d 2 should be f th end Mental by 7 is marked of traumatic ava			Rural Routa Number, City or Town, Stata, Zip Code)						
Mod 2 alth e 27 is read	John Wayne Tenney/Son 6621 Stockton I	ane Hvat	tsville.	MD 20784					
Baltimore, Mipone, Mipone, Moralli e Department of Haalth e Important: If item 27 is any injury or other treatments.	20a. Mathod of Disposition 1	Deta	20c. Location - City of Baltimor	or Town, Stata					
Balti permit. Departm Importa	21. Signatura of Funaral Sarvice Licensae 22. Nama and Address of Facility Cremation So	ity							
	23a. Part1. Enter the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as			MD 21228 Approximate					
Physician /Medical	shock, or haart failura. List only one cause on each line. Immediate Ceuse (Finel disease or condition Multipustum Ordan For	uilve		Intarval Between Onset and Death					
Examiner	Immediata Ceuse (Finel disaasa or condition rasulting in daath) a. Multi system organ for put to (or as a consequence of):	. ^							
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760, be executed sicien and burial-transit	Sequentially list conditions, if any, leading to immediate causa. Enter Undertying Cause (Disease or Injury C. STAPHYŁOCOCCAŁ AUREUS SEPTICEMIA	7 8446							
8760, sate be a shysician the burish	causa. Entar Underlying Cause (Disease or Injury) that initiated evants Dua to (or as a consequence of):	7 DAYS							
	resulting in death) Last NECROTIZING FASCIITIS								
Genth death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1. 23b. Did	23b. Did tobacco use contribute to the cause of death?						
cords, P.O. Be requires that the death requires that the death open signed by the attentional be detached for reted by Physicial	lectal capar		1 Yee 2 No 3 Probably 4 Unknown						
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lecord law requi	Congestive heartfailure	24a. Wa	s an autopsy ormed?	Wara autopsy findings available prior to completion of cause of death?					
f Vital Records, yaldan: The law requires is cartificate has been sign director, page 2 should be to Be Completed by	Diabetes	Yas 2 No	1 Yas 2 No						
Vita Vita Vita Vita Vita Vita Vita Vita	25. Was case rafarred to medical axaminar? 1	a of Death (Check only							
Vision of Vita	1 Yas 2 No rospital 1 Pinpatient 2 ER/Outpatient 3 DOA rospital 4 No 27. Manner of Death 28a. Data of Injury 28b. Time of Injury at Work?	ursing Homa 5 Ras 28d. Describe	idance 6 Other (S) how Injury occurred	pecify)					
Division Tor Attending after deeth. Director: After din by the fune ertification	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accidant Invastigation M 1 □ Yes 2 □] No							
ivis	3 Suicida 6 Could not be datarmined 28s. Placa of Injury - At homa, larm, street, factory, office building, atc. (Specify)	28f. Location City or To	(Street and Number or own, Stata)	Rural Routa Number,					
Ce la Diagram	, constant,								
Division of Vital Records, P.O. Box 6 To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after deeth. To the Funeral Director: After this cartificate has been signed by the attending p completely filled in by the funeral director, page 2 should be deteched for use as Medical Certification: To Be Completed by Physician/Medical Certification:	29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data and manner stated.	nd place, and dua to the ath occurred at the time	cause(s) and mannar , data and placa, and d	as stated. lua to the cause(s)					
To the within To the company	29b. Signatura and titla of certifier 29c. License number		29d. Data signed (Mo	onth, Day, Year)					
	Attay berong, no AT2438946 march 20, 1999								
	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)	ltimore.	mp	10.72					
State	31. Data filed (Month, Day, Year) 32. Registrar's Signature								
Registrar	APR 5 1999 Jimes D. Sparks								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth MARCH TRUDELL 1999 MARY 3:35PM 31 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straat and number) 4c. County of Death HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthpiaca (Stete or Foreign Country) 5. Sociei Security Number Yrs. Feb. 25,1916 10b. County 10c. City, Town or Location Baltimore Rosedale 10g. Citizan of Whet Country? 10f. Zip Code 21237 United States 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White Yaar or Dates: 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumema) Helen Victoria Moler

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Extersiner must be notified at altimore, Maryland 21215-0020 e filed within 7 al Hygiene. Pages 1 and 2 should be file ment of Health end Mantal Hyant: If item 27 is marked oth jury or other traumatic event permit. Page Depertment of Important: If any Injury or page.

Physician

/Medical

Funeral

Director

Show

the Maryland

Physician /Medical Examiner

cartificata be axecuted physician and s the burial-trans P.O. Box 68760. 98 use signed by t Records, Division of Vital

funeral efter death.

Director: Aft
d in by the fur ö Hospital 24 hours completaly within 2 To the I the th

West Virginia 235-18-7859 Usual Residence of Decedent 10e. Steta 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 7419 Brightside Ave. 11 Marital Status 1 Navar Married 26 Married A 3 ☐ Widowed 4 ☐ Divorced leted Elementary/Secondary (0-12) 11 Years 17. Fether's Neme (First, Middle, Last) Be John Franklin Myers 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Irving W. Trudell/Husband 7419 Brightside Ave. Rosedale, Maryland 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State Dete 20a. Method of Disposition cemetery, cremetory or other plece) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 4/3/1999 Middle River, MD 5 Other (Specify) 22. Name end Addrass of Fecility 21. Signature of Funerel Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ter the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximeta Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) & ADULT RESPIRATORY DISTRESS SYNDROME TWO WEEKS Due to (or es a consequence of): Examiner MULTI-LOBAR PNEUMONIA TWO WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.) Due to (or as a consequence of): Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown INTERSTITIAL LUNG DISEASE 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed HYPERTENSION, BILATERAL RENAL ARTERY completion of cause of death? STENOSIS, ADRENAL INSUFFICIENCY 25. Wes case referred to medical axaminar? Be 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner stated. 29a, Certifier (Check only 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifiar RESIDENT PHYSICIAN 97008



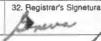
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31. Date filed (Month, Dey, Year)

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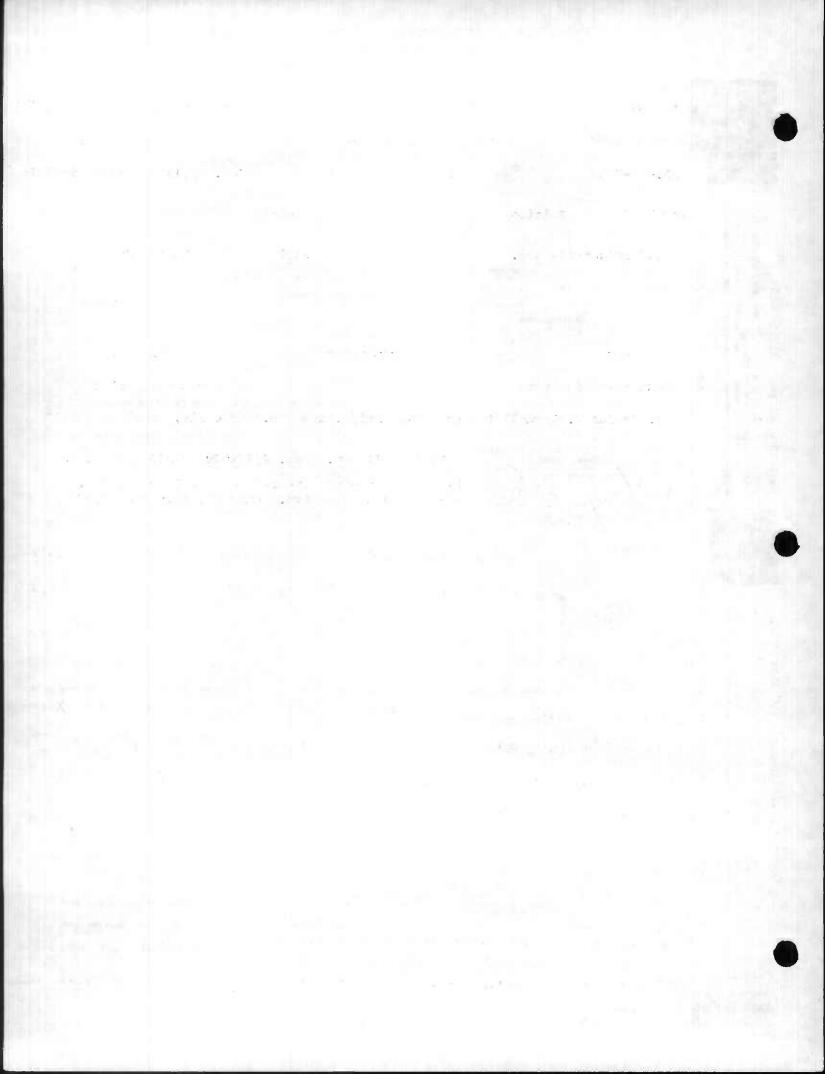
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

D. Sports

MARCH, 31, 1999

4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

DHMH 16 Ray 6/95



State Registrar

29b. Signatura and titla of certifier

Stonen S.

31. Dete filed (Month, Day, Year)

APR 0 5 1999

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Radentz

32. Aegistrar's Signature

within 2 the the

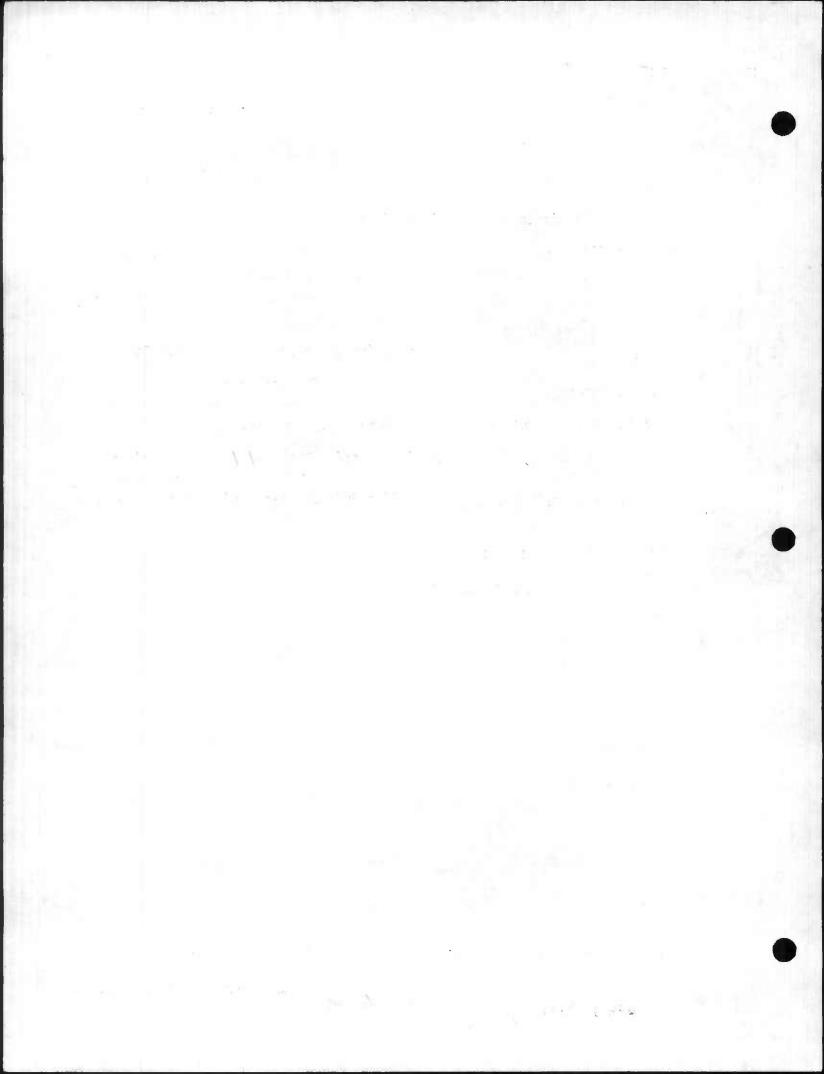
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

March 31, 1999



Registrar

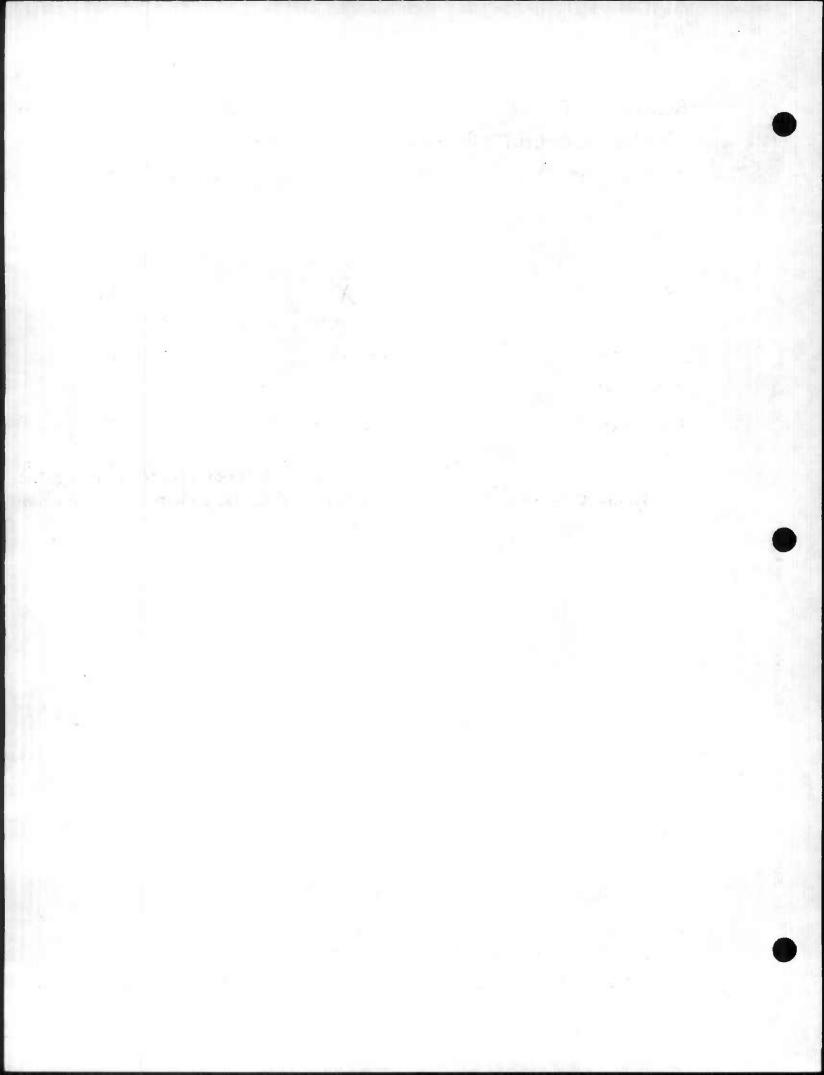
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31. Dete filed (Mohth, Day, Year)

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32. Registratis Signeture

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** RTHEN 1999 3:43 AM GNES /Medical 4c. County of Death N/A 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 02/03/1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F Hours 214-01-2614 Maryland Director Usuaf Residence of Decedant 10a. State 10b. County 10c. City. Town or Location lygiene. other than "natural", or Itama 23a or 28a-f ahow vent, the Medical Examinar must be notified at 10d. Insida City Limits Baltimore MD Baltimore 1 ☐ Yas 2 TNo Director 10g. Citizen of What Country? United States 10f. Zip Code 21227 10e. Street and Number 1115 Taylor Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w. Department of Health and Mental Hygien. Important: If Nem 27 ta marked other the page. 12 Housewife Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 William Washington Wilson Agnes Soper 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnie Warthen/ Son 3901 McTavish Ave. Baltimore, MD 21227 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from Stete 4/7/99 4 Donation 5 Other (Specify) Loudon Park Cemetry Baltimore, Maryland 22. Name and Address of Fecility Ambrose Funeral Home, Inc. of Funeral Service Licen 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final ASPIRATION 3days NEUMONITIS disease or condition resulting in death) Examiner Examiner ROFOUND physicien and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760 EMENTIA MULTI-INFARC Physician/Medical THEROSCIEROSIS zeo 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown EREBROUASCU RRHOSIS Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Disease 10 Tes 20 No 1 Yas 2 No AORTIC STE 25. Was cese referred to medical examiner? legenerative Joint Division of Vital TENOS To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, 8 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 PNeturat 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stefed. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N. M. MACHIRA PRIL who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 720-C MAIDEN Choice LA M. MACHIRAN

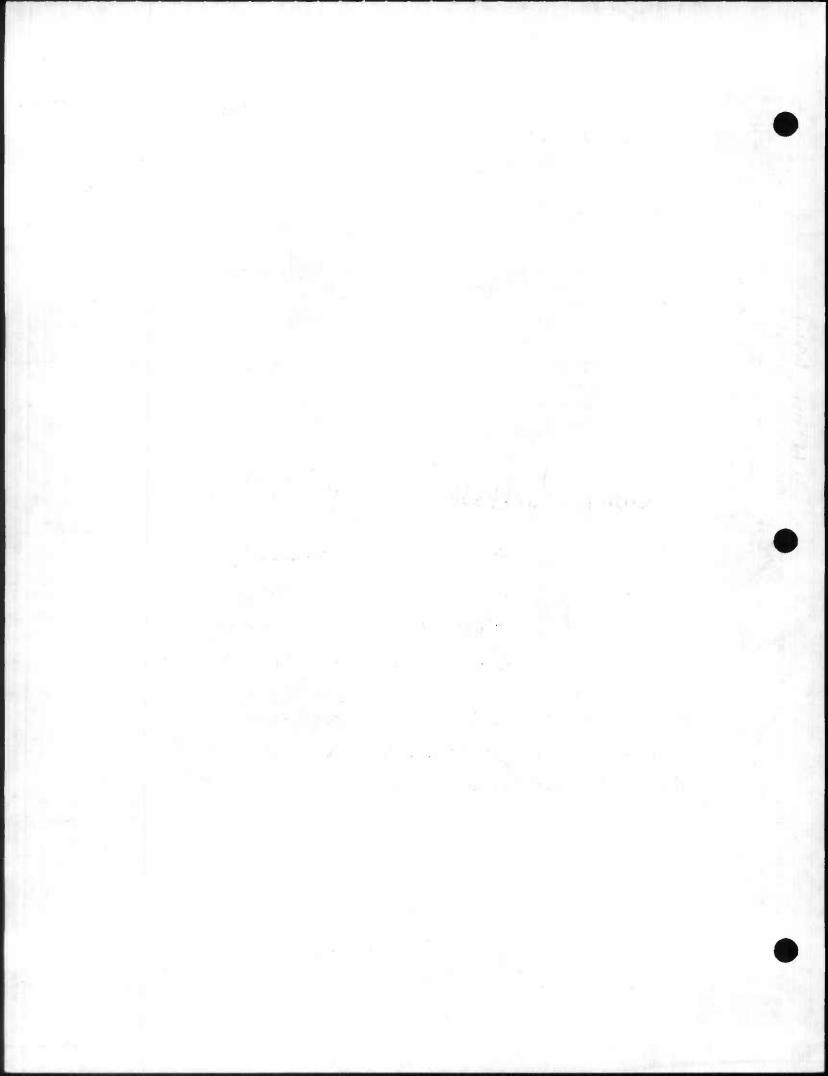
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State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

5 1999



State Registrar 31. Date filed (Month Day, Year)

32. Registrar's Signature

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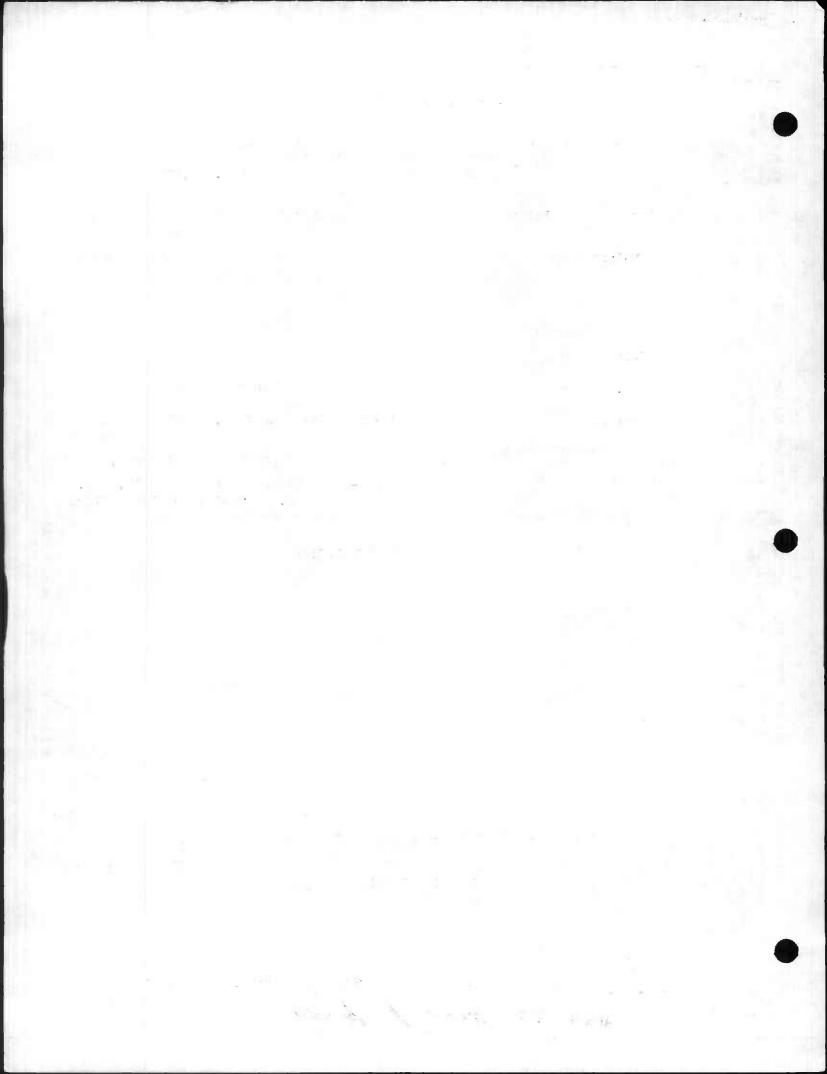
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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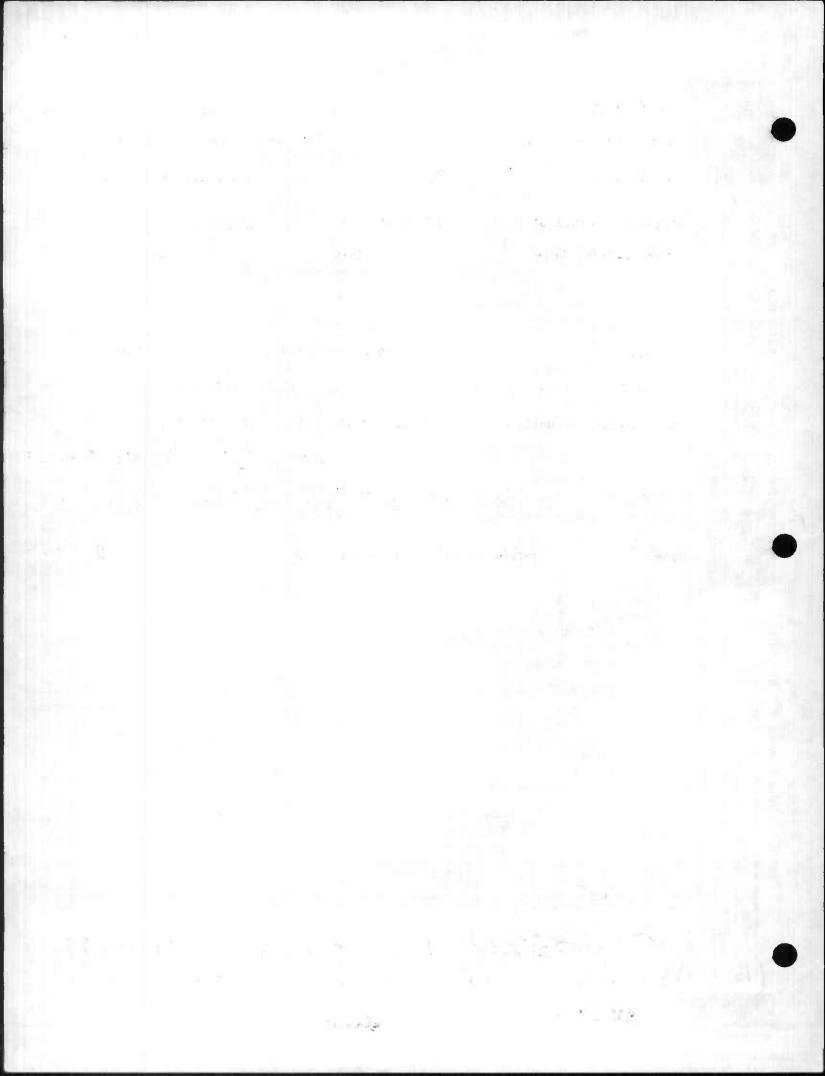
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111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of N	Maryland	-	artment rtificate			d Mental H	ygiene 9	10	0823
	1. Decedent's Neme (First, Middle,	Last)		11 7				2. Dete of I		Yeer	3. Time of Deeth
nysiçian Medical	KAY ARCHER							March		999	12:01 AM
aminer	4e Facility Name (If not institution, 1509 Lorelei		er)					or Location of Dec Shington			rge's
neral ector	5. Sociel Security Number 271–38–2326	6. Sex 1 □ M 2 ☒ F	Age (In yrs. le	est birthday) Yrs.	If Under 1 Months	Yeer Deys	If Under 24 Hours	Min. (Month, I	Birth Dey, Year)	9. Birthple Count	ece (State or Foreign ry)
or or	Usuel Residence of Decedent 10e. Stete 10b. County Maryland Prince	e George's		Town or Lo	ocation shingt	on					d. Inside City Limits 1 X Yes 2 □ No
Examiner must be notified at by Funeral Director	10e. Street end Number 1509 Lorelei D		101	i c was	10f. Zip 0	Code			10g. Citizen of V		ry?
era		12. Wes Deceder	nt Ever in 11 S	12			ionanio Origin	2 (Specify Ves or I		• e - America	n Indian
by	11. Maritel Status 1 Never Married 2 M Marrie 3 Widowed 4 Divorced	Armed Force	s? () No		If Yes, specif			? (Specify Yes or I ruerto Ricen, etc.)	Specify	ck, White, e	tc.
Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-40	or 5+)	(Give life.	DO NOT use	done d	tu <i>ring</i> most of ()		16b. Kind of B		
Con	12th			Prot	cocol	Spe	cialist	t	Gover	nment	
To Be	17. Fether's Neme (First, Middle, L Charles Willa	-	son				18. Mother's Glady	ys Hammo		ne)	
To Be Completed	19e. fnforment's Name/Relationsh							or Rural Route Num			
	Charles Archer	Husband	ool Di					Fort Was			
once.	20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donetion 5 ☐ Other (Sp				sition (Name metory or oth ke Cre			03/18 1999	Beltsv		Maryland
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Physician/M										the cause of death?	
Completed by Physician					4			24a. W	es en eutopsy rformed?	con	re eutopsy findings ileble prior to npletion of ceuse leath?
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To	exeminer?	Hospitel: 1 🗆 Inpa	tient 2 E	R/Outpetie	nt 3 DOA	Oth	er: 4 Nursi	ng Home 52 Re	sidence 6 DOth	ner (Specify)
	27. Manner of Death 1 Active 5 Pending 2 Accident investigation	ition	njury Day Year)	28b. Time of 28c. fnjury et 28d.					8d. Describe how injury occurred		
Certification:	3 ☐ Suicide 6 ☐ Could no determine	200. FIAUS UI	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity)						(Street end Numi Town, State)	ber or Rurel	Route Number,
edicai (29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the bes xaminer: On the basis end menner	of exemineti	rledge, deet on end/or in	h occurred el vestigation, i	t the tin	ne, date end p pinion, deeth	plece, end due to the occurred et the time	ne ceuse(s) end m e, dete end plece,	enner es sto end due to	eted. the ceuse(s)
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/	30. Name and address of person w		deeth (Item	23e) (Type,	Print)	0	ms	2077	4	1	
State	31. Dete filed (Month, Day, Year)	32. Regis	strar's Signat	ure				/ ((



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #1, per Phy. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3/23/99, Carroll County, wjl 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth JEANETTE ALT MARCH 19, **Physician** 1999 12:52 PM JEANNE ALT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 2, 1916 If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2 1 F Months Deys Wisconsin 82 Yrs. 393-09-7561 Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 K Yes 2 □ No Maryland Frederick Directo Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ih and Mental hygiene. 7 is marked other than "natural", or items 23s or traumetic event, the Modical Example: must be a U.S.A. 21727 S. Seton Ave. 331 permit. Peges 1 and 2 should be filed within 72 hours effer deeth. Department of Heelth and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s any Injury or other traumetic event, the Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Merried 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be George Lincoln Scott Maud Woodbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Woodsboro, MD 21798 Lynn Marshall/ daughter 10001-A Woodsboro Rd. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/20/99 Carroll Cremation, Inc. Hampstead, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fundral Service License 404 S. Main St. Woodsboro, MD 21798 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pulmonary disease or condition resulting in death) 10 How Examiner Examiner Fai live 10 How Respiratory physician end the buriel-transit thet the deeth certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that lighted as each Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in deeth) Lest Due to (or as a consequence of): SB 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cardionzopull 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. edicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3-19-99 143091 MD 21701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SARED

MAR 2 3 1999

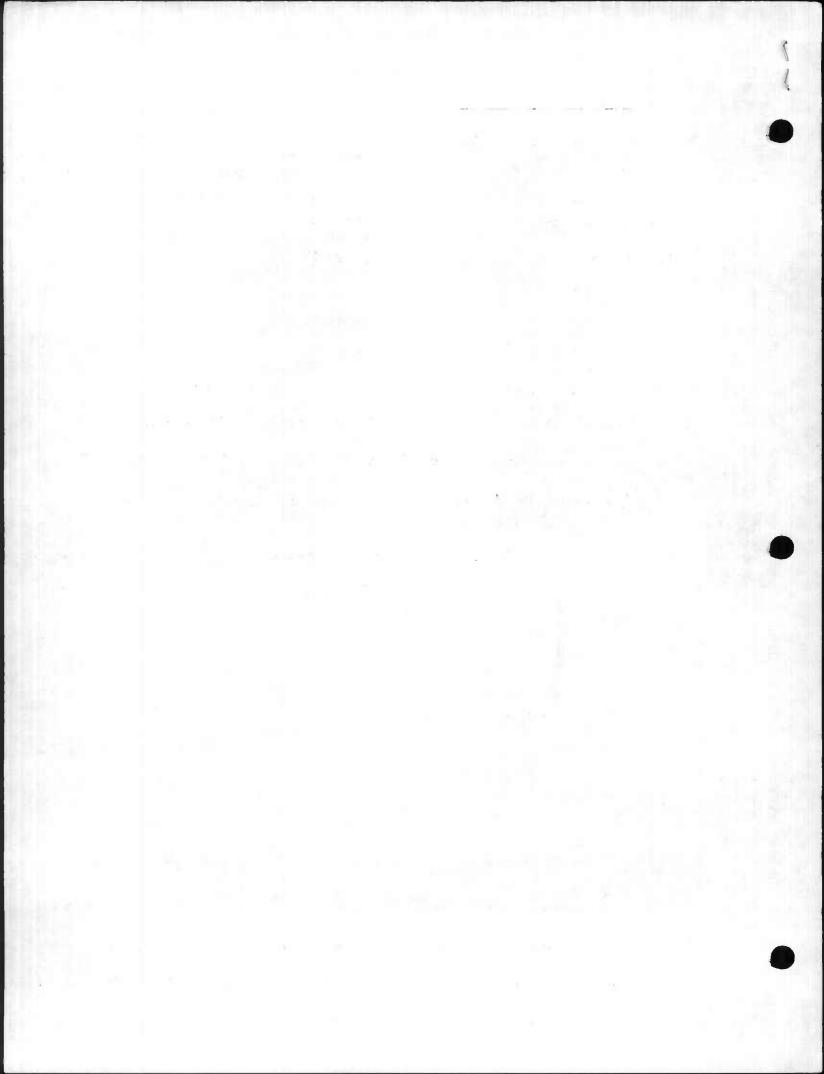
32. Registrar's Signature

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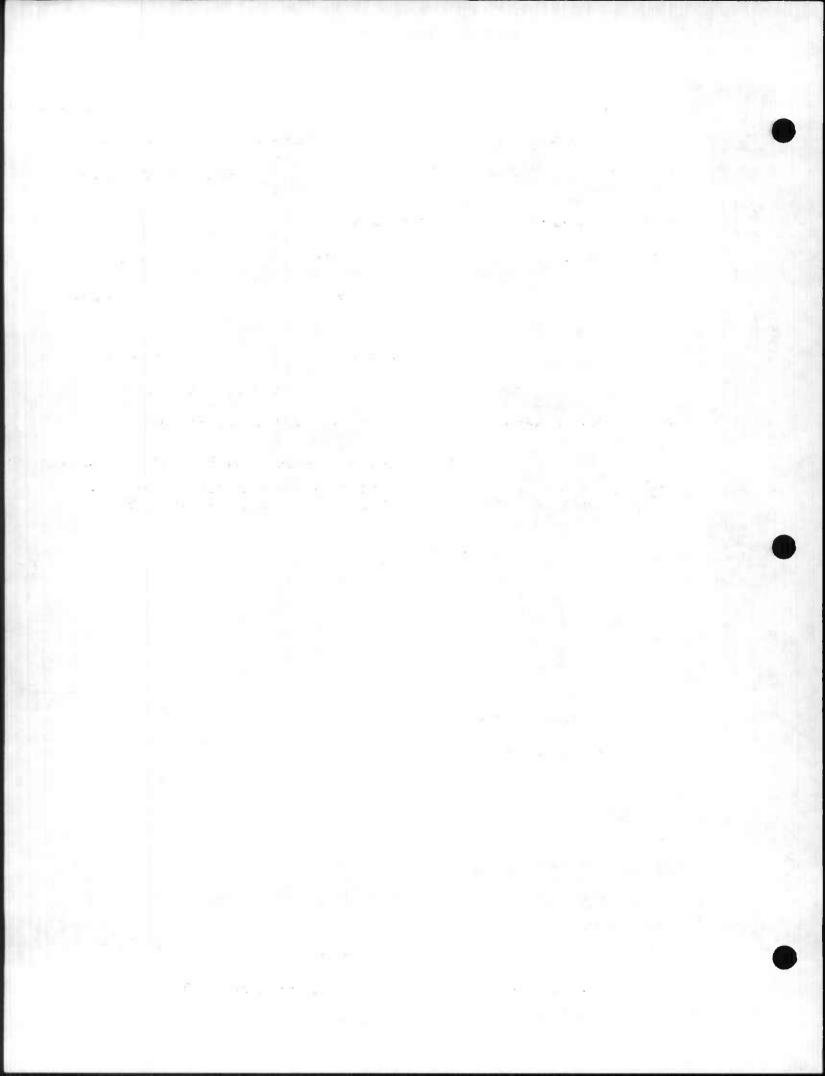
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801 TOLL HOUSE AVE

FREDERICK



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1999 ANDERSON March 4e. Facility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Deeth WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. Hours Min. Hours Min. JULY 20, 1924 If Under 1 Year Birthplece (Stete or Foreign Country)
 MARYLAND 6. Sex 7. Age (In yrs. lest birthday) 1□M 2XF Deys Yrs. 74 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No MARYLAND WICOMICO SALISBURY 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21804 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) OFFICE CLERK WELDING COMPANY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) STERLING STERLING 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) NEW CHURCH, VA 23415 DEAN LeCATES - SON 4058 KELLY RD. 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removal from State 3-25-99 SALISBURY, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) PARSONS CEMETERY 22. Name end Address of Fecility 705 E. MAIN ST. F BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

BERNICE

10e State

Director

Funeral

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Completed

Be 2 5. Social Security Number

218-16-8513 Usuel Residence of Decedent

10e. Street end Number

226 GOLD ST.

12

20a. Method of Disposition

11. Maritai Status

GROVMAN

23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plicetions that caused the death one ceuse on each line.	n. Do not enter the mode of	f dying, such es cerdiec	or respiretory errest,	Approximate intervel Between Onset end Death
Immediete Ceuse (Finel disease or condition resulting in deeth)	. MASSIVE !	BRAIN STEI	A AND BASA	L GANGLIA STR	OKE
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DIABETES 1	NSIPIDUS			1 Yes 2 No	3 Probably 4 Unknown
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings evellable prior to completion of ceuse of deeth?
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25. Wes case referred to medicei examiner?				th (Check only one)	
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27. Menner of Death 1 Natural 5 Pending 2 Accident Investigatio		28b. Time of 1njury M	injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occur	red
3 Suicide 6 Could not be determined		me, farm, street, factory, o	ffice	28f. Location (Street end Numb City or Town, State)	ber or Rurel Route Number,
29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example	ysician: To the best of my knowniner; On the basis of exeminet end menner stated.	vledge, deeth occurred et ion end/or Investigation, in	he time, dete end plece, my opinion, deeth occur	end due to the ceuse(s) end mored et the time, dete end plece,	enner as steted. end due to the ceuse(s)
29b. Signature end title of certifier	0 100		icense number	29d. Date signe	d (Month, Dey, Yeer)
Jour n. M	she MD, P	h.D. D	0054048	03	121/99

attending physician and for use as the buriel-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. signed by the at id be deteched for page 2 s After this certificate has To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, I

State Registrar Jack

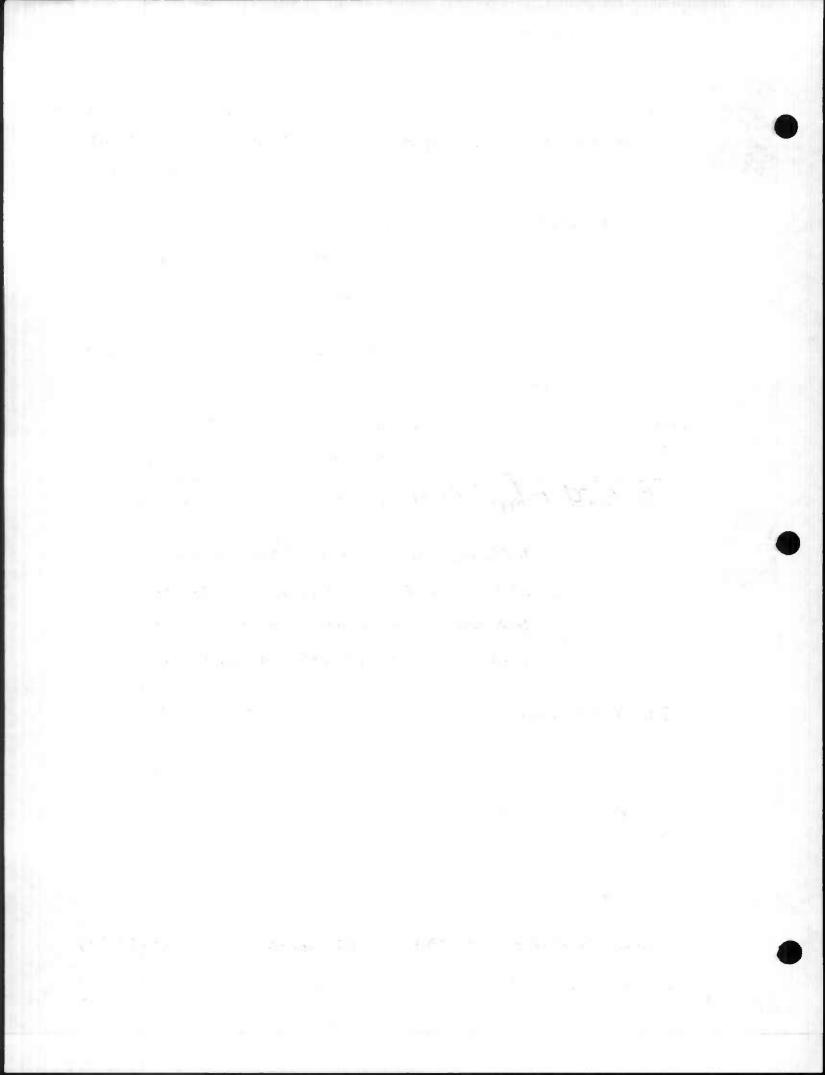
31. Dete filed (Month, Day, Year)
MAR 2 3 1999

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

Malik

560 RIVERSIDE DR A 102 SAlisbury, Md. 21801
32. Registrer's Signeture

Server & Spark;



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Physician /Medical Examiner	
	uneral irector	
nd	*	

with the Maryle

Baltimore, Maryland 21215-0020

1.	Decedent's	Name	(First,	Middle,	Last)
	JER	OM	9		

BATTLE,

46

JR.

2. Date of Death Month

8. Date of Birth (Month, Day, Year)

Day 5, MARCH 1999 3. Time of Death 4:00 pm

4a Facility Name (If not institution, give street and number)

PRINCE GEORGES COMMUNITY HOSPITAL

1**X**M 2□ F

CHEVERLY

4b. City, Town, or Location of Death

PRINCE GEORGES

4c. County of Death

Director notifie permit. Pages 1 and 2 should be filed within 72 hours efter death with t Department of Health and Mentel Hygiene. Important: if tiem 27 is marked other than "natural", or items 23a or any lighty or other treumatic event, the Medical Examiner must be a page. Funeral by Completed

Be

2

Examiner

Physician/Medical

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Completed

Be

Certification: To

edicai

Physician /Medical

Examiner

end I-transit

physician er s the buriel-t

signed t

certificete hes b irector, page 2 s

this funeral

efter death Director:

20

filled in I the Hospital of the 24 hours of the Funeral D

80 use

deeth certificate be executed

Usual Residence of Decedent 10b. County 10c. City, Town or Location

Yrs.

10f. Zip Code

8-21-1952 WASH . DC

10d. Inslda City Limits

Birthplace (Stata or Foreign Country)

MD

10a. State

577-72-8370

PRINCE GEORGES

SEAT PLEASANT

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

10g. Citizen of What Country?

1 Yes 2 No

10e. Street and Number

515 68th STREET

20743 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.)

U.S.A. 14. Race - American Indian. Black, White, etc.

Specify: BLACK

3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

College (1-4or 5+)

1 Yes 2 No If Yes, Give Yaar or Dates:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes X No Specify:

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

12. Was Decedent Evar in U,S. Armed Forces?

CARPENTER

UNION LOCAL 1110

12th

17. Fathar's Nama (First, Middle, Last)

BATTLE,

DOLORES

MAYO

JEROME 19a. Informant's Name/Relationship (Typa, Print)

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

NATAYA I. BATTLE - WIFE

515 68th STREET, SEAT PLEASANT, MD 20743

20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATIONAL MEM. PK

SR.

Date 3-20c. Location - City or Town, State

12-1999 LAUREL, MD

21. Signature of Theral Seprine Licensee

22. Name and Address of Facility

TAYLOR'S FUNERAL HOME

NW WASH.DC 20001 1722 NORTH CAPITOL ST., 236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Maiden Surname)

SYSTEMIC INFLAMATORY RESPONCE SYNDROME

3 months

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Due to (or as a consequence of):

3 months

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): MULTIPLE SCLEROSIS

Dua to (or as a consequence of):

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy tindings available prior to

1 ☐ Yes 2 XNo

completion of ceuse of death? 1 ☐ Yes 2 No

1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 - Homicide 29a. Certifier

25. Was case reterred to medical examiner?

1 Yes 2 No

27. Manner of Death

1X Natural

2 Accident

3 Sulcida

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier eens

5 Pending invastigation

6 Could not be determined

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES CATAVENS - 3001 HOSPITAL DRIVE, CHEVERLY, 31. Date tiled (Month, Day, Year)

32. Registrar's Signature

MAR 1 9 1999

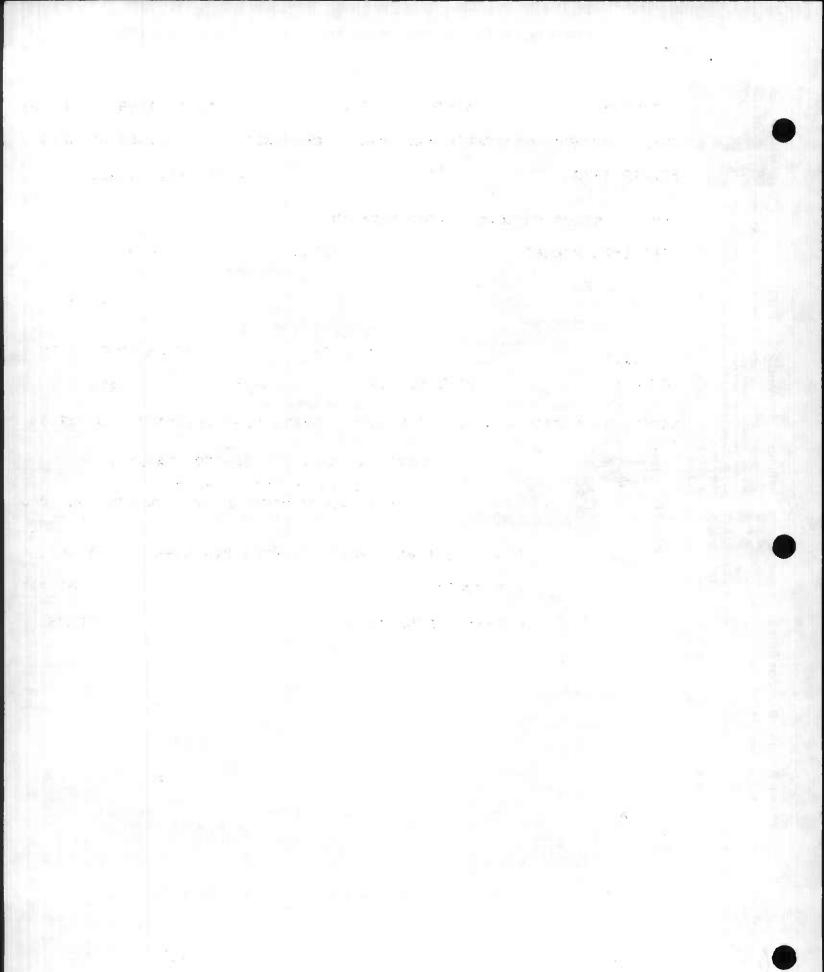
B. Sparke

DHMH 16 Rev 6/95

P.O. Box 68760. Division of Vital Records,

or Attending Physician:

Registrar



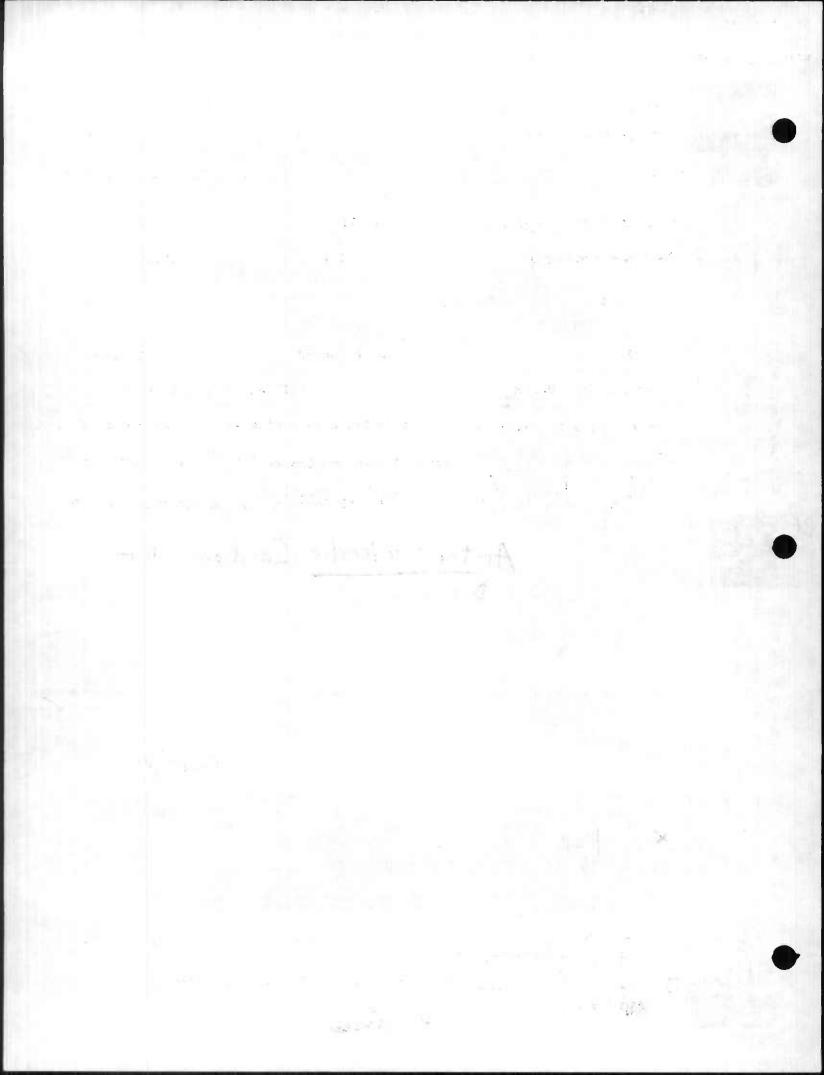
State of Maryland / Department of Health and Mental Hygiene

Stanley Frederick Medical Mospital Info-Dis-392	3.	Certificate of Death	F	Reg. No. 9 9	10828
Tenderal Examiner Fundral Director Frederick Medical Hospital Frederick Medical Frederick Medical Hospital Frederick Medical Hospital Fr		1. Decedent's Nama (First, Middla, Last)			3. Time of Death
## Countries Frederick Medical Hospital Frederick	Stanley Wilbur Baker			9:11 am	
S. Social Script Number Company Public Very Book Very Company Very Very Company Very Ver		4a Facility Nama (Il not institution, give street and number) 4b. City, Town,			
Social Society Number 20 Service Service 10 20 10 10 10 10 10 10		Frederick Medical Hospital Frederick	rick	Fred	erick
Total Comment Total Commen	Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Data of Birth		
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A 739 Baltimore Avenue, Hyattsville, MD 20781	arthur Arten		(03/13/99	brentwo	od, ratytand
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Physician //Medical Examiner The physician //Medical Examiner Physician //Medical Examin		23a. Part1. Enter the diseasa, or complications that cauted had death. Do not enter the mode of dying, such as card	liac or raspiratory an	rest,	Approximata
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	ar de recte la by ti	determined 288. Placa of Injury - At noma, farm, street, factory, office			r or Rural Routa Number,
	Cer in Dia				
29a. Certifier (Check only one) 29a Certifier (Check only one) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	Hospi E4 hour Funer itely fill	(Check only 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death or	ce, end due to the occurred at the time, o	cause(s) and man data end place, ar	ner as stated. nd dua to the cause(s)
and manner stated. 29b. Signature and title of pertilier 29c. License number 29d. Data signed (Month, Day, Year)	Med mple	. and manner states.		29d Date sinned	(Month Day Year)
29c. License number 29d. Data signed (Month, Day, Year) March 12, 1999	F. 3 T. 8	250. Exemper number	29d. Data signed (Month, Day, Year) March 12 1999		
D31058	(m) 111			- Maria	
30. Nama and/address of person who completed causa of death (Item 23a) (Type, Print)	20) Vo				700
Gene F. Ashe, MD, 10200 Coppermine Road, PO Box 6, Woodsboro, MD 21798			woodsbord	o, MD 21	/98
State Registrar 31. Data filed (Month, Day, Year) MAR 1 5 1999 32. Registrar's Signatura	State	MAR 1 5 1999			

DHMH 16 Rsv 6/95

State of Maryland / Department of Health and Mental Hygiene Q

hysician				Certifica	e or i	Dealii		F	leg. No.		
•	1. Decedent's Name (First, Middle, L	ast)						Date of Dee		Year	3. Time of De 1410
/Medical	Arthur Saul	Beach							13 ^{Day} 199	9	1110
Examiner	4a Fecility Neme (If not institution, gr 4907 EASTERN AV					HYATT	SVII		PRIN		EORGES
uneral rector	5. Social Security Number 6. 077-24-7848	Sex 7. Age 1∭2 M 2□ F	(In yrs. last birth	Months	Days	Hours	Min.	B. Dete of Birth (Month, Day July 22	, Year) 2, 1932	Coun	lace (State or Fi try) York
show det	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location						1	0d. Inside City L
or 28e-fah be noursed Director	Maryland Prince 10e. Street and Number	George's	Ну	attsvi	11e				10g. Citizen of W	/het Coun	1 Tes 2
0 Z	4907 Eastern Av	enue			207	82			U.S.A.		
or, or items 234 Examinet must by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: K			cify Cube	lispenic Original, Mexican, Specify:	n? (Spec Puerto Ri	ify Yes or No- icen, etc.)	14. Race	k, White,	
	15. Decedent's E	ducetion	16a. D	ecedent's Usi	el Occup	etion	of constant		16b. Kind of Bu		
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traumatic To	19a. Informant's Name/Relationship	(Type, Print)							er, City or Town,		
other tr	Faye A. Goliwas 20a. Method of Disposition	- Daughter	20b. Place of D			ther K	ing	Ave.,	Charlest		
- 2	1 ABuriat 2 ☐ Cremation 3		cem etery.	crematory or	other plac		03/	/22/00			
any Injury once.	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	A	Marylar			Cemete ss of Facility	ery		Cheltenh	nam,	Marylan
any l)-lo. V	E/)		Gasch'	s Fu	neral	Home	, P.A.	!11		00701
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused t	he death. Do no	t enter the mo	de of dyir	more A	venu ardiac or	e, Hya respiretory er	ttsville	e, ML	2078] Approximete Interval Between
ing physicien and se as the bunal-trensit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. D	SEAS Due to (or es e co	ensequence of	:			2(800	scula		
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ed by the attend detached for us	Part II. Other significant conditions	contributing to death but	not resulting in t								
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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Barham 1999 Bessie Ann March 12, 9:00 am · /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Prince George's Larkin Chase Nursing Home Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys Hours Min. 1□ M 2⊠ F Yrs. 66 579-42-4922 Dec. 17, 1932 North Carolina Usual Residence of Decedent 10e, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Prince George's Greenbelt Maryland 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number U.S.A. 6942 Hanover Parkway, #200 20770 Funeral 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 N Married 1 Yes 2 No Specify: P White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Education Secretary 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Miltimore Clara Mae Roberts William Bryan 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 6942 Hanover Parkway, #200, Greenbelt, MD 20770 Paul Preston Barham - Husband 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 Cremation 3 Removel from State 03/15/99 4 ☐ Donetlon 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Neme end Address of Fecility 21. Signature of Funerel Servica Licensee Gasch's Funeral Home, P.A. audette Dasc 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) e CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND 1+ Years GYDANIDECT. Della Consolidado de la consolidado della consol Spritt Examiner CACHEXIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Intury that initiated events resulting in death) Lest Due to (or es e consequence of): Array A. Docat Physician/Medicai Due to (or es e consequence of) 236 Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 N Unknown ANEMIA. P 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed STATUS POST LEFT FEMUR SURGERY DUE TO FRACTURE completion of cause of deeth? SECONDARY TO OSTEOPOROSIS 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel Be 26. Place of Deeth (Check only one) To 1K Yes 2□ No Hospitel: 1 ☐ Inpelient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. 29a. Certifier edical 29b. Signature end title of card 29c. License number 29d. Date signed (Month, Day, Year)

physician and s the burial-transit the death certificate be executed Box 68760. attending pl the signed by the Records, ils certificate hes t director, page 2 s Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifice funeral rector: / A 24 hour. The Funeral Direction To the Hosp within 24 hou To the Funer completely fil

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Exercises must be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

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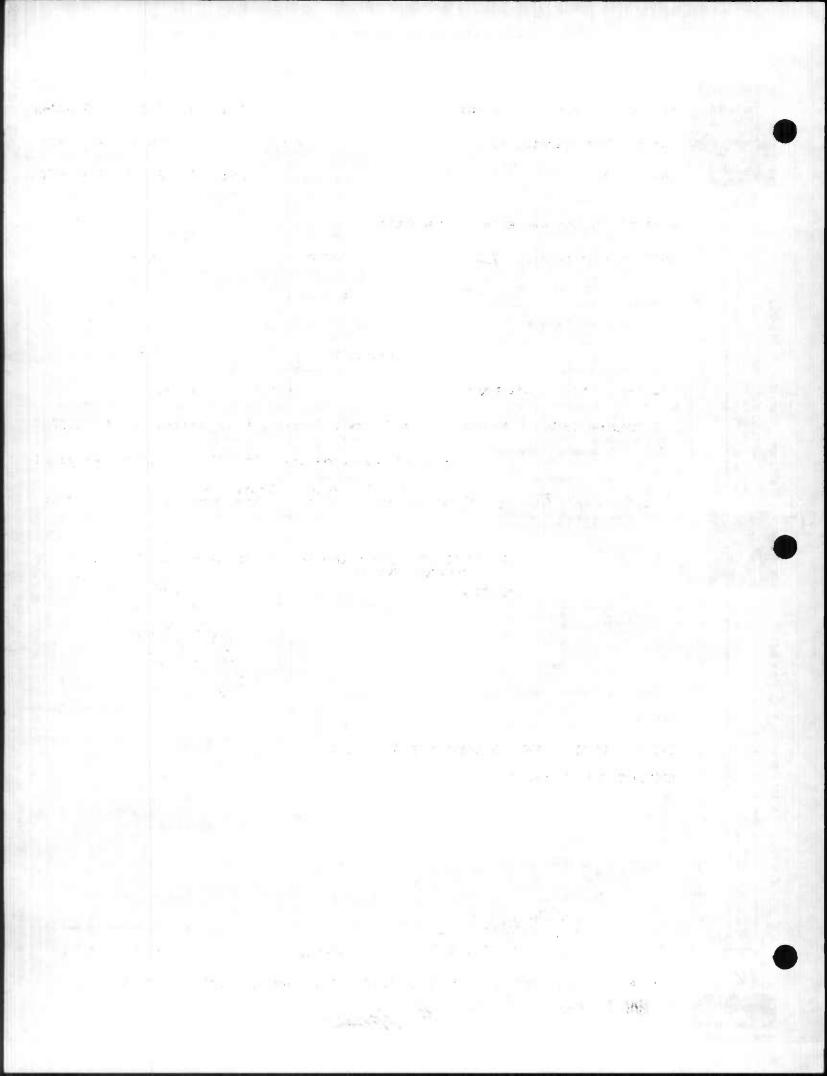
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



D34525

March 16, 1999

Registrar



		State of Maryla		artment of F rtificate of I			ene 9 9	10831
Physicia /Medic		Decedent's Neme (First, Middle, Last) ARABELL BOYD				2. Deta of Death Month March 1	Dey Yeer 2. 1999	3. Tima of Death 5:45 AM
Examin		4a. Facility Name (If not institution, give street and number) ManorCare Nursing Home			ib. City, Town, or Lo Largo		4c. County of Death	1
Funeral Director		420-48-6927 1□M 2ૐF	rs. last birthday) 88 Yrs.	If Undar 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey,) 2-22-1	Year) 9. Birth	nplace (State or Foraign untry)
the Meryland 28a-f ahow notified at	tor		City, Town or Lo					10d. Inside City Limits 1 ☑ Yas 2 ☐ No
ith with the 23e or 28 ust be not	Funeral Director	10e. Street end Number 2121 Parkside Drive		10f. Zip Code 20721		100	g. Citizen of What Cou USA	untry?
er des	þ	11. Merital Stetus 1 □ Navar Married 2 □ Married 3 □ Widowed 4 ₺ Divorced 12. Was Decedent Evar in Armed Forces? 1 □ Yas 2 ₺ No ff Yes, Give Yeer or Detes:	Ì	Wes Decedent of H If Yes, specify Cubs	ispanic Origin? (Spe an, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)	14. Race - Amer Bleck, Whita Specify: B1a	i, etc.
Maryland 21215-0020 at 2 should be flied within 72 hours eft manded other than "netural", or traumetic event, the Medical Example transmitted of the Medical	Be Completed	15. Decedent's Education (Specify only highest grada complated) Elemantary/Secondery (0-12) 12 College (1-4or 5+)		lent's Usuel Occup kind of work dona o DO NOT use retired	ation during most of worki i)	ing 16	Sb. Kind of Business/	
E 2305	To Be C	17. Fether's Neme (First, Middle, Last) Nelson Boyd			18. Mothar's Name Alice	Molton	aiden Sumema)	
		19e. Informent's Neme/Relationship (Type, Print) Leonard N. Williams 20e. Mathod of Disposition	2121	l Parksid	e Drive,	Mitchell	City or Town, State, Z ville, MD Oc. Location - City or 1	20721
Baltimore, emit. Pages 1 ar bepartment of Hea moortant: If them I my injury or other ince.		1 ⊠ Buriai 2 □ Cramation 3 □ Removel from Stata 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Uconylo	armony N	sition (Name of natory or other place Memorial	Park 3	3-17-99	Landover,	
W #9##8		23a Natt Enter tha disaase, or complications that caused the de nock, or heeft feilure. List only one cause on each line.			town Rd,	Camp Spr	ings, Md	20748
Physician /Medical Examiner		Immediete Ceusa (Final disease or condition e. Se	2PSi	5				Intervel Between Onset end Deeth
876(cete be physicle the bur	edical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	(or es a consequence of the cons	uence of):	enn S	fuile.	les	Months days.
cords, P.O. Box 6 requires that the death certification is seen signed by the attending include be deteched for use as	Physician/Me	d Part II. Other significant conditions contributing to death but not re	esulting in the ur	ndarlying cause giv	en in Pert I.			to the cause of death?
bed the st	þ					1 Yse	eutopsy 24b. V	Vere autopsy findings ovallable prior to
I Rec	Completed					1 ☐ Yas	•	ompletion of cause of deeth?
hyste hyste of life	n: To Be	25. Was case referred to medical examiner? Yes 2 No	ER/Outpatien	f 3□ DOA Oth	er: 4 Nursing Ho	(Check only one) me 5 ☐ Residen 28d. Describe how	ce 8 Other (Spec	ify)
	Certification:	2 Accident invastigation 3 Sulcide 6 Could not be determined building, etc. (Special Country of the Country of	home, farm, stre	M 1 🗆	Yas 2□No	28f. Location (Stre City or Town,	et end Number or Ru State)	ral Route Number,
Hospi 14 hou Funer tely fill	edicai	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my kr check only one) 2 Medical Examiner: On the basis of examiner and menner stated.	nowledge, deeth netion end/or inv	occurred et the timestigetion, in my of	ne, dete end pieca, opinion, deeth occurr	end due to the cau ed et the time, det	se(s) end menner es e end plece, and due	steted. fo the cause(s)
To the To the comple	W	29b. Signature and title of certifier	7.	29c. Licenso	e number	7 8 290	d. Date signed (Month	Day, Year)
0		30. Name and address of person who completed cause of death (Ite		13°6 H	he	and	MJS	10785
Stat Registra		31. Deta filed (Month, Dey, Year) 32 Registrer's Sign ARR 1 7 1999	4	bar		U		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Year MARIE **BROOKS** 5'30 AM Merch 13 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Deaton Specialty Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. lest birthdey) Birthpiace (State or Foraign Country) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🗙 F 49 March 7, 1950 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1XXVes 2 No Bowie 10f. Zip Code 10g, Citizen of What Country? 13304 - 8th Street 20715 U.S.A. 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Bus Driver Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earnest H. Lewis Theresa Wood 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerome Brooks/Husband 13304 - 8th Street, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 03/24 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete Maryland Veterans Ceme. Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1999 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the feeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List on one ceuse on each line. Approximate Interval Between Onset and Death stage chrone rand failure 1 YEAR Dicheter mollitys 20425 Due to (or as a consequence of): 11 1 pertonsian Due to (or es e consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

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Peges 1 and 2 ment of Haalth a

Baltimore, Maryland 21215-0020

BKOOKS

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Box 68760,

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Division of Vital Records.

death.

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

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VALLORIE

218-52-9473

10e. Street and Number

10a State

Usual Residence of Decedent

12th

20a. Method of Disposition

physician and the buriel-transit requires that the death certificate be executed for use es 98 signed by the a d be detached f been sign The lew is cartificate has to director, page 2 s Attending Physician: this

Examiner Physician/Medical þ Completed Be Certification: To funeral Aftar after death Director: /

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

omoric encophalpathy

Immediate Cause (Final disease or condition resulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

en wire

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of

28e. Dete of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

PPHOE C

3/13/99

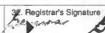
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KDESTIM Deaten medical control GII south charles street Balhmane mD 2/230 31. Date filed (Month, Pay, Year)

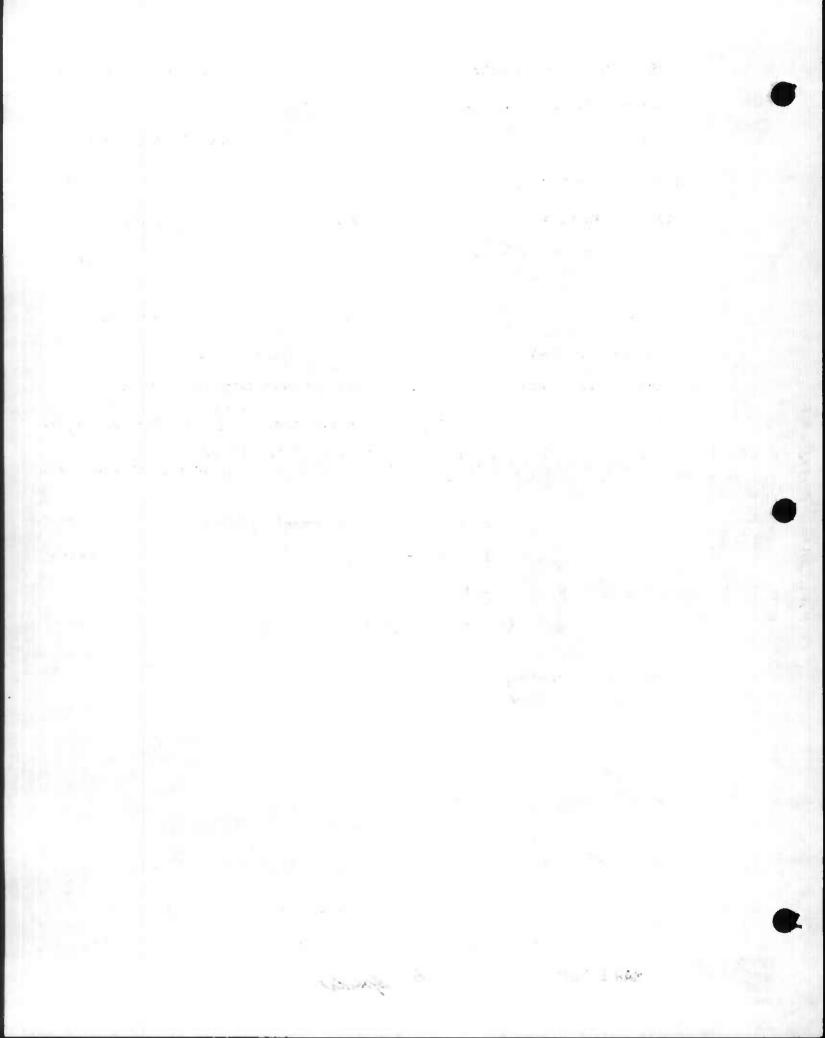
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Registrar

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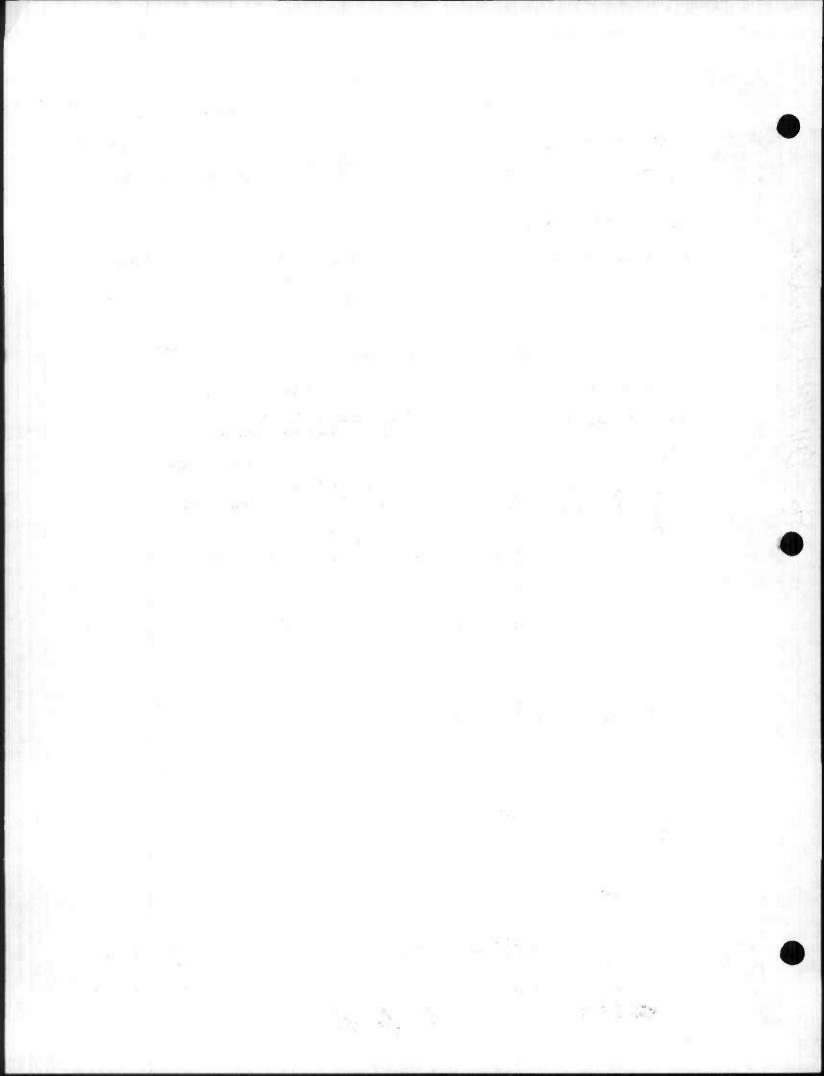






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 3 3

al Rasidence of Decedent State 10b. County D Prince G Street end Number 14 Kings Heathe Maritel Status 1 Naver Married 2 Married 3 Widowed 4 Divorced 15. Decedant's E (Specify only highest gr. Ilementery/Secondary (0-12) 9th Fether's Nama (First, Middle, Last ames Cooper Informent's Name/Ralationship (1bur Barham (so Method of Disposition Burial 2 Cremation 3 D A Donation 5 Other (Specify Signeture of Funeral Service Lice A Part Enter the disease or comshock, or haart failure. List only mediate Causa (Final base or condition ulting in deeth)	BARHAM Iva street end number) AL Sax 1	16a. Deced (Give lifta. D Homer 19b. Mailin 1214 Place of Dispos cemetery, crem T. Barha 22.	ille 10f. Zip Code 2072 Was Dacedent of Yes, specify Cu 1 Yes 2 Notent's Usual Occ kind of work don DO NOT usa retin maker ang Address (Street Kings Cheelly of the Street Cheell Cheel Chee	A Hours Min. 21 Hispenic Origin? (Suban, Maxican, Puerlo Specify: upation le during most of wored) 18. Mothar's Nate Salone et end Number or Rutheather Ite, MD. lece) Lery less of Facility 11's Funer th St. NW	pecify Yes or No o Rican, etc.) pecify Yes or No o Rican, etc.) rking me (First, Middle, Everett ral Routa Number) 20721 unkn al Home Washing	Dey 13,1990 14c. County Prince th, Year) 1917 10g. Citizen of V United 14. Race Blace Specify 16b. Kind of Bu Priva Meiden Sumam er, City or Town, 20c. Location - Como,	of Death e George's 9. Birthpleca (Steta or Fore Country) COMO., N.C. 10d. Insida City Lim 1X Yes 2 Whet Country? States 9. American Indian, sk, White, atc. 17. Black Usinass/Industry ate 1a.) Stete, Zip Code) City or Town, State N.C.
Facility Neme (If not institution, gineral Security Number 6.3 (27-78-5143) all Rasidence of Decedent 10b. County ID Prince G Street end Number 14 Kings Heather Maritel Status 1 Divorced 15. Decedent's E (Specify only highest grade) Stementery/Secondary (0-12) 9th Fether's Nama (First, Middle, Last ames Cooper 1. Informent's Name/Ralationship (1. Informent's Name/Ralation	AL Sax 10 M 2NF 81 10c. George's Mi 11c. Was Decadant Evar In Armed Forcas? 11c. Was Decadant Evar In Armed Forcas? 11c. Yes 2ND No If Yas, Give Year or Dates: Education rade complated) Collega (1-4or 5+) (Type, Print)	U,S. 13. V III 16a. Deced (Give) III 16a. Deced (Give) III 17a. D. Homer III 19b. Mailing 1214 M1t. C. Place of Disposemetery, crem T. Barha 22.	Months Day cation ille 10f. Zip Code 2072 Was Dacedent of Yes, specify Cu 1 Yes 2 N dent's Usual Occ kind of work don DO NOT usa retin maker g Address (Street Kings Chellvil Stion (Name of Name of Near pater) am Cemet Name end Add Marshal 4217 9t	Lanham ar If Under 24 Hrs s Hours Min. 21 If Hispenic Origin? (Suban, Maxican, Puerlo o Specify: upation le during most of wored) 18. Mothar's Nat Salone et end Number or Rt Heather I Lle, MD. lece) Lery lress of Facility L1's Funer th St. NW	pecify Yes or No o Rican, etc.) pecify Yes or No o Rican, etc.) rking me (First, Middle, Everett ral Routa Number) 20721 unkn al Home Washing	4c. County Prince thy, Year) 1917 10g. Citizen of V United 14. Racion Black Specify 16b. Kind of Bu Priva Meiden Surnam er, City or Town, 20c. Location Como,	of Death e George's 9. Birthpleca (Steta or Fore Country) COMO, N.C. 10d. Insida City Lim 1X Yes 2 Whet Country? States e-Amarican Indian, sk, White, atc. (** Black usinass/Industry ate 18) Stete, Zip Code) City or Town, State N.C. 20011 Approximate Interval Between Interval Between
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death March 15, Physician Ruth Borsos 1:20 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4620 N. Park Ave. Apt. 608E Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 15 1923 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 25 F Months Days Hours 106-24-6567 75 Yrs. Germany Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner rount be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 🌪 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4620 N. Park Ave. Apt. 608E 20815 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Jewish Council for College (1-4or 5+) 5+ Elementary/Secondary (0-12) Social Worker the Aging 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Moser Elsa Bloch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tibor Borsos/Husband 4620 N. Park Ave., Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 3/15/99 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home 21. Signature of Fundal S rvice Licensee 254 Carroll St., Washington, DC 20012 auto disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Ovanar Canas /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, physician Physician/Medical 2 Due to (or as a consequence of) **USB 28** attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yes 2 146 3 Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings evailable prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 WHO 1 Yes allo 89 25. Was case referred to medical examiner? 26. Place of Death (Check only me) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 8 Other (Specify) 2 1 Yes After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of or Attending 1 Neturei 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 19 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) March 15, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Frederick P. Smith 5401 Western Ave., Washington, DC 20015

State Registrar 31. Date filed (Month, Day, Year) MAR 1: 6 1999

32. Aegistrer's Signature

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State of Maryland / Department of Health and Mental Hygiene 9 9

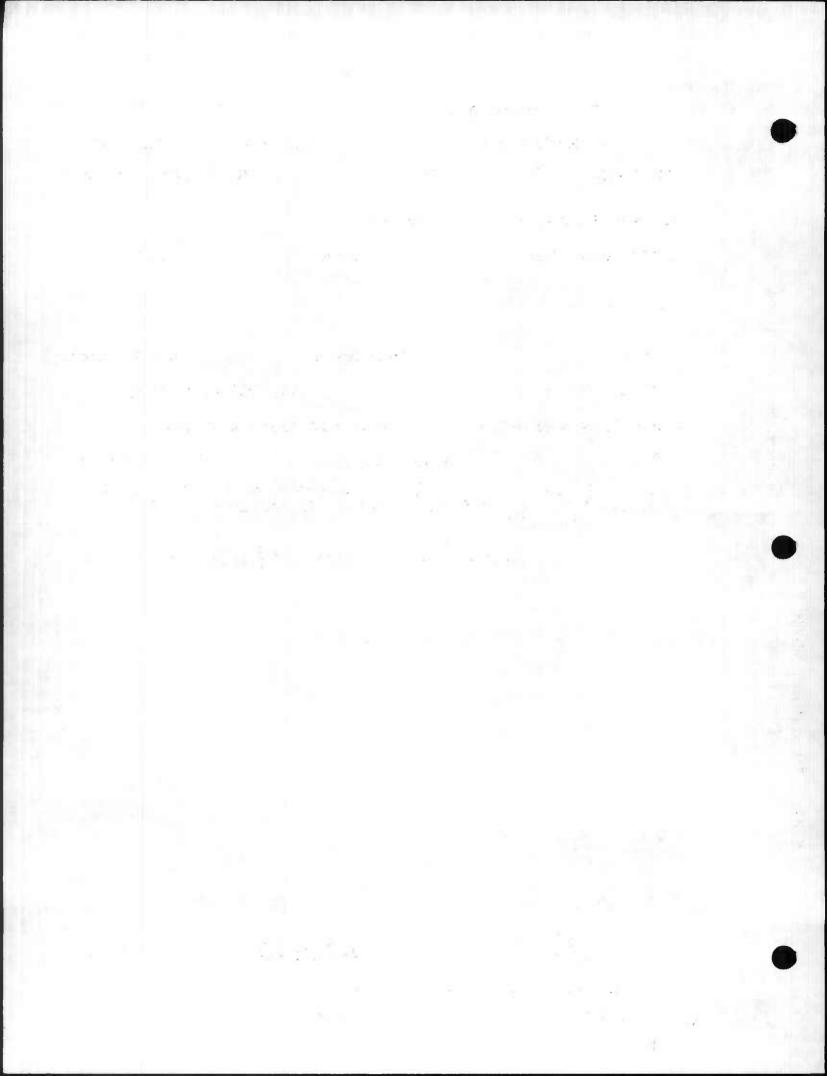
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MAR 1 8 1999

KELSO FARRELL BEAVER



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month March 23, Dey 1999 **Physician** 2211 Margaret Rose Berry · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 24 Hrs. 8. Dete of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 ■ F Maryland 62 Yrs. January 14, 1937 217-74-5365 Director Usual Residence of Decedent the Marylend 10a Stale 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 20653 46738 Willow Forest Lane United States Funerai death 12. Was Decedenf Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates: 14. Raca - American Indien. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "naturel", or flee any Injury or other traumetic event, the Medical Examine 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A Homemaker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Mary Cecelia Trent Frank St. Ignatius Berry 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 46738 Willow Forest Lane, Lexington Park, MD 20653 Robert S. Berry, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removel from Stete 3/29/99 Helen, Maryland Queen of Peace 4 ☐ Donation 5 ☐ Other (Specify) Succession Supplied Supplied 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. Brissfield, Edward N. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onsef end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Lest thet the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending p for usa as signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 has 1 ☐ Yes 2 No cartificate 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending P
 24 hours after death.
 Funerel Director: After ti After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dele end place, and due to the cause(s) and menner as stated.

1 Madical Examiner: On the basis of examination end/or Investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Si nd title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and

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32. Registrer's Signeture

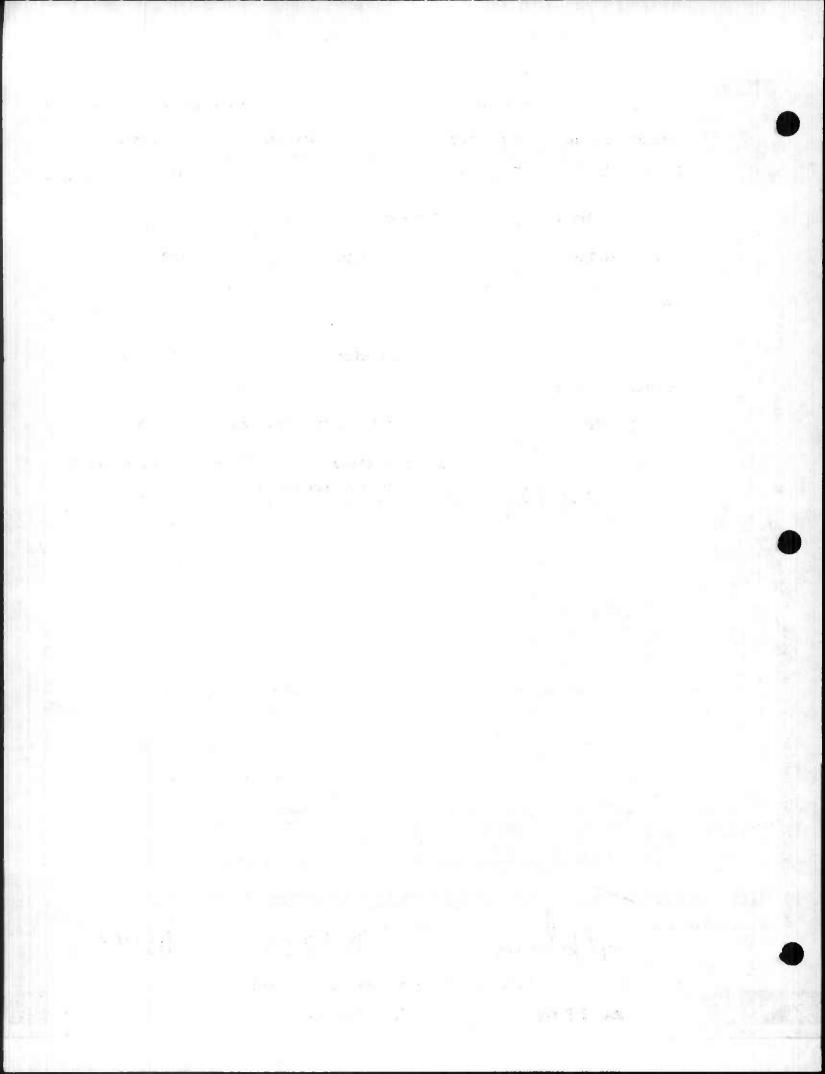
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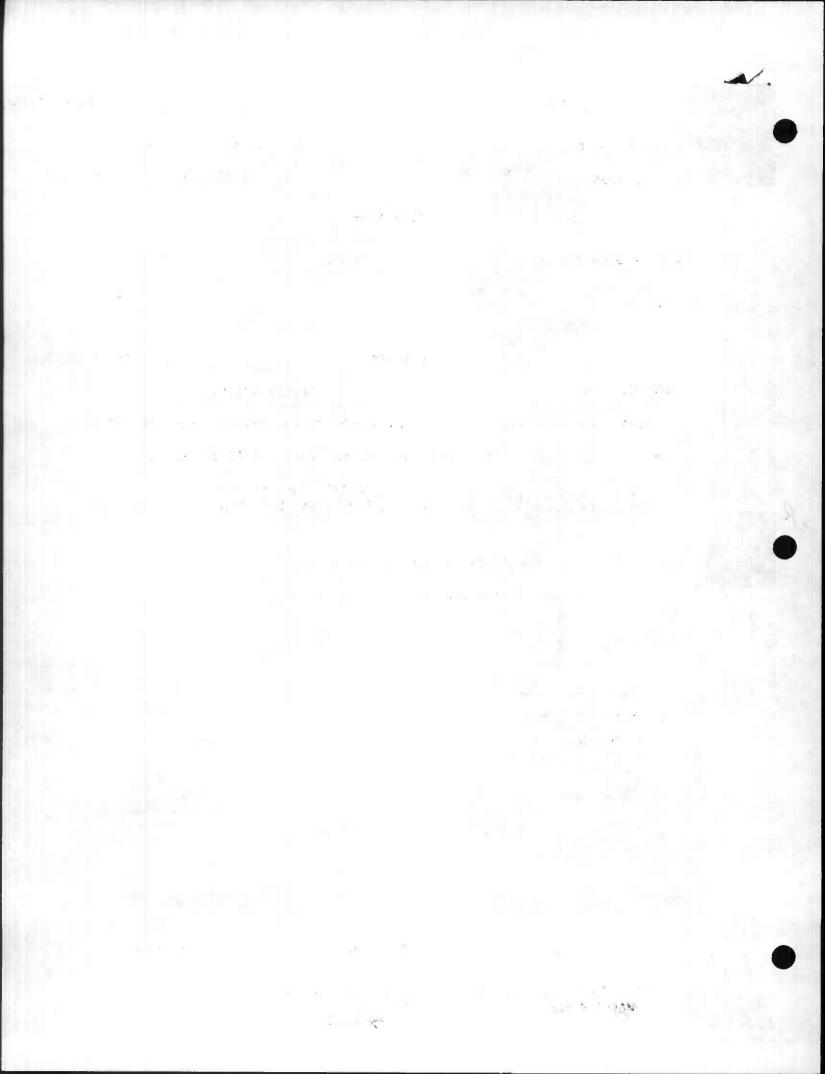
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State of Maryland / Department of Health and Mental Hygiene 9 9 10839

				Cer	tificate	of I	Death		F	Reg. No.		9000
1. Decedent's Nam	HI CONTRACTOR					2. Date of Month				ate of Death onth Day Year		3. Time of Death
ian DAVII	D CH	ARLES	WOR	TH					MAR	14	99	7:34 AM
		a street and numbe			-	4	b. City, To	wn, or Lo	cation of Death	4c. Co	unty of Death	
Howard	County Ge	eneral Hos	spital			- (Colum			How	ard	
5. Social Security N 230-60-	6669 ×	Sex 7. /	Age (In yrs. last bi	irthday) Yrs.	If Under 1 Months	Days Days	If Undar Hours	24 Hrs. Min.	8. Data of Birt (Month, Da) 7/28/4	r, Year)	9. Birthp Coun PA	laca (Stata or Foraign try)
Usual Rasidence o	Decedent 10b. County		10c. City, Tow	vn or Lo	cation						1	0d. Inside City Limits
MD	Prince (Georges	Laure									1 ☐ Yas 2/QNNo
	dar Lane				101. Zip 0	4				US	of What Cour A	itry?
3 ☐ Widowed	ied 2☐ Married	12. Was Deceder Armed Force 1 12 Yas 2 I If Yas, Giva Yaar or Datas	s?] No		Vas Decede Yas, specil		ispanic Ori an, Mexican Specify:		ocify Yas or No- Rican, atc.)		Race - Americ Black, Whita, ecity: Whi	atc.
VSner	15. Decedent's Ed		16a	. Deced	ent's Usual kind of work	Occup	ation	t of worki	pa	16b. Kind	of Businass/Inc	dustry
(Special Elementery/Second 12		College (1-4o	r 5+)	life. L	ectri	retired	1)	I O WOIN		U.S.	Gov't	
17. Fathar's Nama	(First, Middle, Last,)					18. Motha	ar's Nama	(First, Middla,	Maiden Sui	mama)	
Kenneth	Charlesv	vorth					Li1	lian	Kenned	y		
t 9a. Informant's N	ame/Relationship (Type, Print)	198	b. Meilin	g Address ((Street	and Numbe	er or Rure	I Routa Numbe	r, City or To	own, Stata, Zip	Code)
Diane K	lein - Da	aughter		622	Fauqu	ier	Rd.,	War	renton,	VA	20186	
	MCremation 3 □	Removal from Stat	20b. Place of cemata Metro	ary, crem	natory or oth	her plac		3/	Dete 18/99		ion - City or To ndria,	
	5 Other (Specif		netro	_	Nama and				10/99	неха	nurra,	VA
23a. Part1. Entar ti shock, or haa	ha disease, or com	plications that co	the death. Do line.								t., Hei	Approximata Intarval Batween Onset and Death
Immediate Causa diseasa or condition	(Final	Resp	nvatory	F	ailu	re						hows
rasulting in death)			Due to (or as a	conseq	uence of):							
elic		, Seve	eve C	OP	D						i i	years
Sequentially list co if any, laading to in causa. Enter Unde Cause (Disease or that initiated events	nditions, nmediate erlying		Dua to (or as a	conseq	uence of):						1	
Cause (Disease or that initiated events rasulting in death)	irijury s Last	C	Dua to (or as a	consequ	uence of):						1	
Death Other steel	Hanna ann dialana	d	h. 4 - 4	- d			an in Day 1		Date Did			the street of death 2
Part II. Other signif	- pneun		Feb. 19					1	1 b(bably 4 Unknown
for res	pirator	y fail	ine (Fel	٦.١	499)_			24a. Was perfo	an autopsy med?	av	ere eutopsy findings ailable prior to mpletion of causa deeth?
	olism,	homele	essness						101	as 2 K		Yas 25 No
25. Was casa refar examiner?	Walter Street,	Hospital:	:/			Oth	er-		(Check only o			
27. Manner of Deat		1 □ Inpa 28a. Data of In		-	3 DOA		4 LINU		ma 5 ☐ Rasio 28d. Describe h			y)
27. Mainter of Deat	5 Pending	(Month, E		Tima of Injury	M 28	c. Injun Worl	yat k? Yas 2□		Luc. Describe r	₩ anjury O	- United	
27. Manner of Deat Statural 2 Accident 3 Suicide 4 Homicide	invastigation 6 Could not be determined	9 28e. Place of I	njury - At home, fa alc. (Specify)	arm, stre			- 00 2		28t. Location (S City or Tow		lumber or Rurs	al Routa Number,
29a. Certifier (Check only one)		ysician: To the besininer: On the besis and manner:	of axaminetion ar									
29b. Signature and	title of certifier				29c.	License	e number			29d. Data s	igned (Month,	Day, Year)
DV.		-	- IAAA		1)3	14-	13		Mar	de 14	11995
30. Nama and addr	ass officeren who	Tomos hetelomos	death (Item 33-1	(Tune I	Print)	- 3	7	-				21042
DIA-TO	1 C 2 A	To VI			5 Hei	100	nde !	Core	e lala	B	Mag H	Tib Mb
ate 31. Date filed (Mon	th Day Year)	32. Regis	strar's Signature	.50	3,101				_ 0000	8	M CD ()	
ate St. Date III A D	7 1000	50. 00	may Signature		1	-/**				0		

Respondent Fallows

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Record procuments (Fate (1971), inhibited for neapsindary facture (Ico 1944)
Alcoholism, lamalessness

HATTER A. TOVE, MD VERS HEMLE de Cone Was Ellisation All

State of Maryland / Department of Health and Mental Hygiene 99 108 in 0

				Ce	ertificate of	Death	1	eg. No.		0040			
п	Physician	1. Decedent's Neme (First, Middle, La			2. Dete of Dee Month	Dev Ye		3. Time of Deeth					
	/Medical	Rudolph Earl		4b. City, Town, or	March	5th 1999 4 4c. County of Deeth		4:15 p					
	Examiner	4e Fecility Neme (If not institution, give Southern Mar		Clinto			rince Georges						
	Funeral Director			yrs. lest birthda 1 Yrs.	Months Deys			Year) 1937	9. Birthple Count W1 T	ece (Stete or Foreigny) ndsor, N			
	filed within 72 hours efter death with the Maryland Wylone. Wher then "natural," or items 23s or 28s-f show ant, the Marical Exercising must be notified at a Completed by Funeral Director	Usuet Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit											
										1 Yes 2 □ No			
		10e. Street and Number 8612 Reno Cour	10f. Zip Code 207			0g. Citizen of W							
21215-0020		11. Maritel Stetus 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes:	r in U,S. 13	. Wes Decedent of If Yes, specify Cul	Hispenic Origin? (S ben, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	pecify Yes or No- D Rican, etc.) 14. Rece • Americ Bleck, White, Specify: B1					
15-0	"natui ofice letec	15. Decedent's E (Specify only highest gra	16e. Dec (Gh	edent's Usuel Occure kind of work done	upation a during most of wo ed)	rking	16b. KInd of Business/Industr						
212	permit. Peges 1 and 2 should be filed within 72 hours eft. Deperment of Health and Mental Hygiens. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Exercisions. To Be Completed by F	Elementery/Secondery (0-12)	ondery (0-12) College (1-4or 5+)		Sorter	9 <i>a)</i>		UPS	UPS				
land		17. Fether's Neme (First, Middle, Last Pocahontas Ch						ne (First, Middle, Maiden Sumame) abeth Bazemore					
Maryland		19a. Informent's Neme/Reletionship (Type, Print) Loretta Cherry 19b. Meiling Address (Street end Number or Rural Route Number, City or 8612 Reno Court Clinton, M							or Town, Stete, Zip Code)				
Baltimore,		20e. Method of Disposition 1 ☒ Burlel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	20b. Place of Disposition (Name of cametery, cremetory or other place)			Dete 20c. Location - City or Town, Stete						
Baltii		4 Donetion 5 Other (Specify) Harmony Memorial 3-11-99 Landover, N 21. Signature of Fundational States Licenses BK Henry Funeral Chapel, INC. Sarah Branch 420 H Street NE Washington DC 200											
		23a. Pert1. Enfer the disease, or com shock, or heart failure List only	AND ADDRESS OF THE PARTY OF THE						DC	Approximete Intervel Between			
	Physician /Medical Examiner Examiner Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	b	to (or es e cons	equence of):	er			1 1 3 3 1	16 mos			
ó	cien: The law requires that the deeth certificete be entificite hes been signed by the ettending physicial botor, page 2 should be deteched for use es the but Be Completed by Physician/Medical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or es e consequence of): Due to (or es e consequence of):											
68760,		Ceuse (Diseese or Injury that Initiated events resulting in death) Lesf	cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Lesf Due to (or es e consequence of):										
Вох			d										
P.O. E		Pert II. Other significant conditions of	23b. Did tobacco use contributa to the cause of										
of Vital Records,		24e. We per							en eutopsy rmed? 24b. Were euto eveilable p completior of deeth?				
Vital R							1 🗆 Y	es 2 N No	1 🗆	Yes 2□ No			
		25. Wes case referred to medicat examiner?	26. Plece of Deeth (Check only one) Hospital: Other: Other										
	2 00 0	1 ☐ Yes 2 Ø No 27. Manner of Deeth	28e. Dete of Injury	2 ER/Outpati	ent 3L DOA		ome 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred						
Division	To the Heaptal or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	(Month, Day Ye	ar) tnjury	M 1[Yes 2□No							
Div		4 ☐ Homicide determined	building, etc. (S	City or Town, Stete)									
	To the Hospital of within 24 hours of To the Funeral D completely filled i	29a. Certifter (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner as steted. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner stated.											
	withi Com	29b. Signeture end title of certifler 29c. License number 29d. Dete signed (M. 29d. D							(Month, 1	Day, Year)			
(10/	30. Name end eddress of person who	ALA, MP.	(Item 23e) (Type	Print)	on Rd, A	Tent wi	sk me	1,20	744			
Ē	State Registrar	31. Date filed (Month, Day, Yeer) MAR 1 7 1999	32. Registrer's	Signature .	park								

DHMH 16 Rav 6/95

School of the second state of the second sec

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner

GARY I. CARTER

1. Decedent's Neme (First, Middle, Last)

Funeral Director

with the Meryland r than "natural", or items 23a or 28a-f ehow the Medical Examinat must be notified at deeth

permit. Pages 1 end 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Med cal Exertinal page.

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the buriel-transit the death certificata be axecuted as esn signed b page 2 s certificate hes After this

P.O. Box 68760. Division of Vital Records, after death. 6 24 hours Funerel

To the Hosp within 24 ho To the Fune completely f

2. Dete of Deeth 3 Time of Death MARCH. 13, 1999 Gary Ike Carter, Sr. 0345 AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1⊠M 2□ F 577-76-2727 42 Yrs May 17, 1956 Wash., D.C. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ♥ Yes 2 No Maryland Prince George's Capitol Heights Directo 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 20743 United States 512 Millwheel Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 11 Maritel Stetus 1 Never Married 2 Merried 1 √ Yes 2 □ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Real Estate Consultant Self-employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) George Roland Carter, Jr. Della Jamison 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Della Greene - Mother 512 Millwheel St., Capitol Heights, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State Fort Lincoln Cemetery 3/18/99 Brentwood, MD 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licenti 22. Name end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the could be read feiture. List only one cause on each line. To not enter the mode of dying, such as cardiec or respiratory errest, Approximete Onset end Deeth Immediate Ceuse (Final disease or condition resulting In deeth) hurnes STABLUOUM Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 10 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient ★XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2□ No 10 28e. Dete of Injury (Month, Dey Year) O 300A M 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Neture! 1 Yes 2 No answer us STABBERO. 13 99 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1708 Changen Pring GEORGE HO ME 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MARCH 13, 1999 O.C.M.E MW

111 Penn Street, Baltimore, Maryland 21201

State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

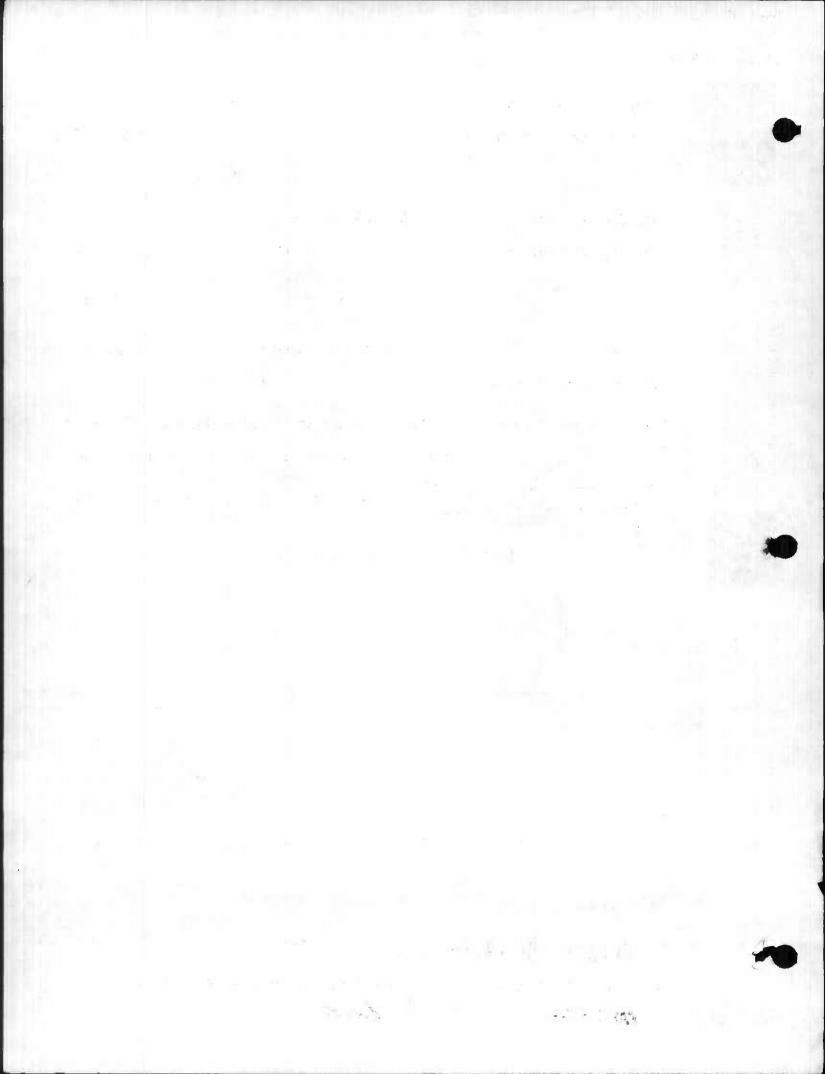
Korrow

32 Registrer's Signeture

MARypning

MAR 1 6 1999

31. Dete filed (Month, Day, Year)



		C	Certificat	e of L	Jeath			Reg. No.	0 0	, 0	1.00
1. Decedent's Neme (First, Middle, Las							2. Dete of De Month	Day		'ear	e of Death
al Marjorie Virgin							March		19		25 am
er 4a Fecility Neme (If not institution, give							ation of Deet	- -	county of		,
Doctor's Communit 5. Sociel Security Number 6. Se		rrs. last birtho	rlav) If Under		Lanha		B. Date of Bir			George	
	□M 2⊠F 66		Months	Deys	Hours	Min.	(Month, De	av. Year)	33 M	. Birthplaca (Sta Country) lary Land	
Usual Residence of Decedent											
10a. State 10b. County	10c.	City, Town o	or Location							1.	City Limits
Maryland Prince G	eorge's Bo	wie									'es 2□No
Maryland Prince G			10f. Zip							at Country?	
7018 Highbridge R			207					U.S.			
7018 Highbridge R 11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ever in Armed Forces?	13. Was Deced if Yes, spec	dent of Hi cify Cuba	spanic Orlg n, Mexican	in? (Spec Puerto R	ify Yes or No ican, etc.)	or No- C.) 14. Race - American Indie Black, White, etc.			١,	
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		1 ☐ Yes	2 ⊠ No	Specify:			S	Specify:	White	
		16a. D	ecedent's Usua	al Occupa	ation			16b. Kind	d of Busin	ness/Industry	
(Specify only highest grad	te completed)	10	Give kind of wo ife. DO NOT us	ork done o	lurina most	of working	9			,	
Elementery/Secondary (0-12)	College (1-4or 5+)	Home	emaker					Own	Home	e	
17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden S	umame)		
Henry Lewis Adams					Mary	Peti	res Wr	ight			
19a. informant's Name/Relationship (7)	ype, Print)	19b. N	Mailing Address	s (Street a	and Numbe	r or Rural	Route Numb	er, City or	Town, Ste	ete, Zip Code)	
Melvin William Co					ge Roa	ad, B	owie,	Maryl	land	20720	
20a. Method of Disposition		 b. Plece of D cemetery, 	Disposition (Ner crematory or c	me of other plac	a)		Date	20c. Loca	ation - Clt	ty or Town, Stat	Ð
1 ☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 03/17/99 Brentwood, N								d, Mary	land		
21. Signature of Funeral Service Licens	600		22. Name ar Gasch	nd Addres	s of Facility	У Ноте	РΔ				
It Constan	re Elas	-/	ouscii	O T C	IICIGI	LICILIC	- 3	•			
		Van	4739 B	alti	more	Avenu	*		ille	, MD 20	781
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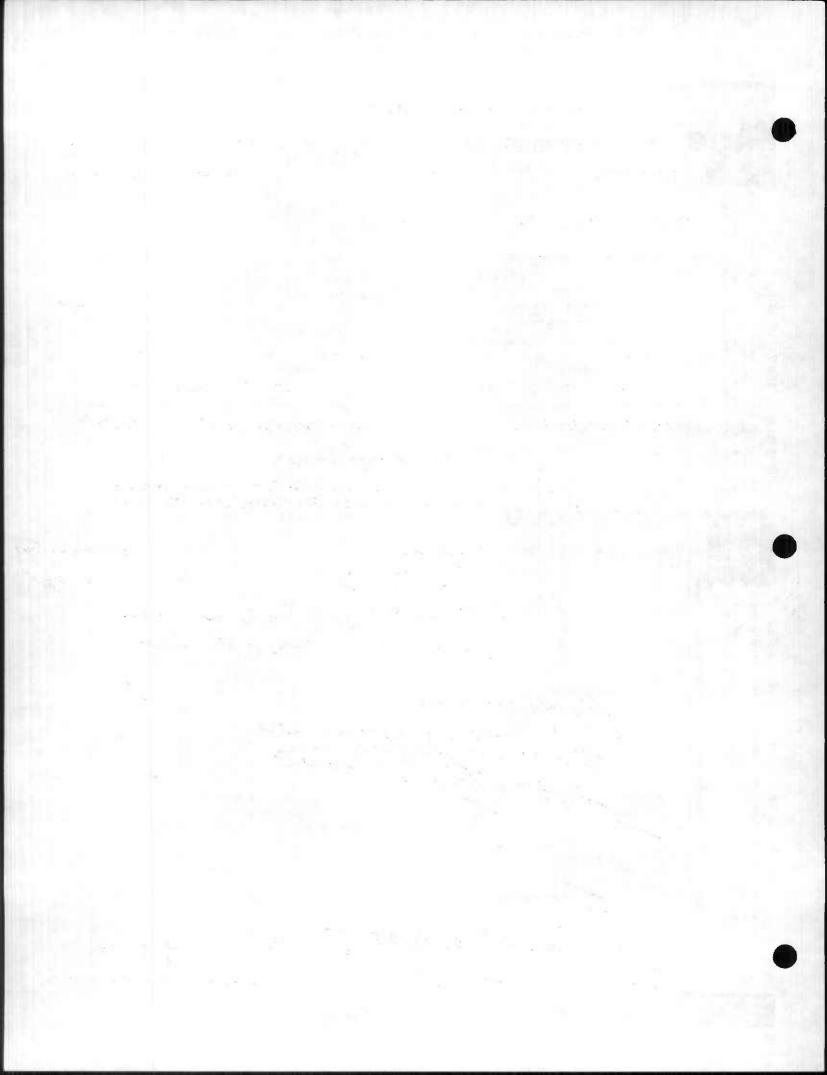
State Registrar Louis Steinberg, M.D.

31. Date filed (Month, Day, Yeer)

MAR 1 6 1999 6492 Landover Road, Landover, Maryland 20785 2. Registrar's Signature

The Pilit San Arm 15 was a special and an Arm

		State	of Maryland		artment o <i>rtificate d</i>				eg. No. 99	10843
Physician	1. Decedent's Nama (First, Middle		Virginia	Came	eron			2. Date of Deal Month March	Pay 1999	3. Time of Death 1:00 AM
/Medical	4a Facility Name (If not institutio			Call	ELOII	4b. Ci	ity, Town, or Lo	cation of Death	4c. County of Dea	th
Examiner	St. Mary's						onardto		St. M	
	5. Social Security Number	6. Sex	7. Aga (In yrs. les	st birthday	If Undar 1 Y		Undar 24 Hrs.	8 Date of Birth		
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ylenc wow	10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
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after death with the Maryler or items 23s or 28s-f show trites must be notified at / Funeral Director	10e. Street and Number				10f. Zip Coo	le		1	0g. Citizen of What Co	ountry?
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should be filed within 72 hours after death with the Maryland of Mentel Hygiena. marked other than 'natural', or items 23a or 28a-f show unratic event, the Medical Estimate must be notified at To Be Completed by Funeral Director	Charles Pl	nilip Lo	ng				Emma	Elizabe	th Wise	
2 sh and is m	19a. Informant's Name/Ralations	ship (Type, Pnnt)		19b. Maili	ing Address (St	reet end f	Number or Rure	I Route Number	r, City or Town, State,	Zip Code)
and ealth n 27	Joan Wilson/Da	aughter		445	45 White	e Pir	ne Ct.,		rnia, MD 2	
of He	20a. Method of Disposition 1 XBurial 2 ☐ Cramation	3 □Removal from	n State Cerr	netery, cre	osition (Name of metory or other	plece)	i		20c. Location - City or	Town, State
Pages nant of I	4 Donation 5 Other (S		Quee	en of	Peace	Cemet	tery 3	/16/99	Helen,	MD
permit. Pages 1 and 2 should be filled within 72 hours Obepartmant of Health and Mentel Hygiena. Importants if item 27 is marked other than "natural", any injury or other traumatic event, tra Mencel Engines. To Be Completed by	21. Signature of Funeral Servica	Licensee	UN	7 2	2. Name and Ad Matting	ddress of ley-(Facility Gardine	r Funera	al Home, P	.A.
	Michael	1 gues	Spard-	1	P.O. Box	270	, Leona	rdtown,	MD 20650	
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/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)	θ	Sepe	reg					5-2	recorder
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effected. To the Funeral Director: After this certificate has been signed by the etending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:	00-0-45-								41	
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier Certifyin	aminer: On the	basis of examination	edge, dear n and/or in	n occurred et tr nvestigation, in i	ny opinio	n, death occurr	ed at the time, o	euse(s) and manner e date and place, and du	s stated. e to tha cause(s)
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	30. Name and address of person					CENT	ר מ משת	DOVE ! O	HOLI STRIOOD	MD 20626
	DAVID FEDERLE	M.D.			MEDICAL	CENT	LEK P.O	. Δυλυ40	HOLLYWOOD	, rm . 20030
State	31. Date filed (Month, Day, Year, MAR 1 5		Ragistrar's Signatur	4	Span	1				
Registrar	MUIV T 9	1000	7		MINOU	2				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1 Decedant's Nama (First Middle Last) Month March 13, 1999 Pearl Agnes Currie 5:45 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown 8. Data of Birth (Month, Day, Yaar) June 18,1906 If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. iast birthday) Birthplace (Stata or Foraign Country) Deys Months Hours 1 M 2 XF Yrs. Maryland 217-68-7717 92 Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 🖾 No St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 22680 Cedar Lane Court 20650 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Year or Datas: Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: White 3 ₩ Widowed 4 Divorced 15. Decadant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumema) Jim Brown Bertie Gatton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) Francis Jessie Currie/Son P.O.Box 634, Great Mills, MD 20634 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crametory or other placa) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Charles Memorial Gardens 3/18/99 Ieonardtown, Maryland 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. ardiner P.O.Box 270, Leonardtown, MD 20650 23a Part Enter the disaasa, or complications that caused the daath. Do not antar the moda of dying, such as cerdiac or raspiratory arrest, shock or heart failure. List only one cause on aach lina. Approximata intarval Batween Onsat and Death Immediata Causa (Final disaesa or condition rasulting in daath)

Physician /Medical **Examiner**

attending physician and for use as the buriel-tran

ed by the a

need pege 2 s cartificate hes

After this

eftar death.

24 hours

To the I within 2

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Be

Certification: To

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88

that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

permit. Pages 1 and 2: Department of Health at Important: If item 27 is sny Injury or other trau page.

1 end 2

Physician

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

other traumatic event,

the Marylend

with

2 should be filed within 72 hours after deeth in and Mental Hygiena.
Is marked other than "naturel", or itema 23s

altimore, Maryland 21215-0020

Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated avents Physician/Medical rasulting in daath) Last þ Completed

25. Was cesa rafarred to medical

29b. Signature and title of certifie

Jam

31. Date filed (Month, Day, Yaar)

Due to (or as a consaquance of):

Due to (or as a consequance of):

Dua to (or as a consequance of):

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i.

23h. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown

24a. Was an autopsy

1 Yss

2 NO

24b. Were autopsy findings availabla prior to complation of ceusa of daath?

26. Placa of Death (Chack only one)

1 ☐ Yas

1 Yas 20 No	Hospitel: 1 Inpatient	2 ER/Outpatient	3□	DOA Other:	4 Devising H	Home 5 Residence 6 Other (Specify)
27. Manner of Death Natural 5 Panding 2 Accidant investig	tion	28b. Tima of Injury	М	28c. Injury at Work? 1 ☐ Yas	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicida 6 ☐ Could n 4 ☐ Homicide determine		At homa, farm, straat	t, fact	ory, office		28f. Location (Street and Number or Rural Routa Number City or Town, Stete)

29c. Licanse number

1 Certifying Phyeician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation in my onlines. 29a. Certifier (Check only iner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s)

29d. Data signed (Month, Day, Year)

ath (Itam 23a) (Type, Print) arson who completed easse of

California, MD 20619

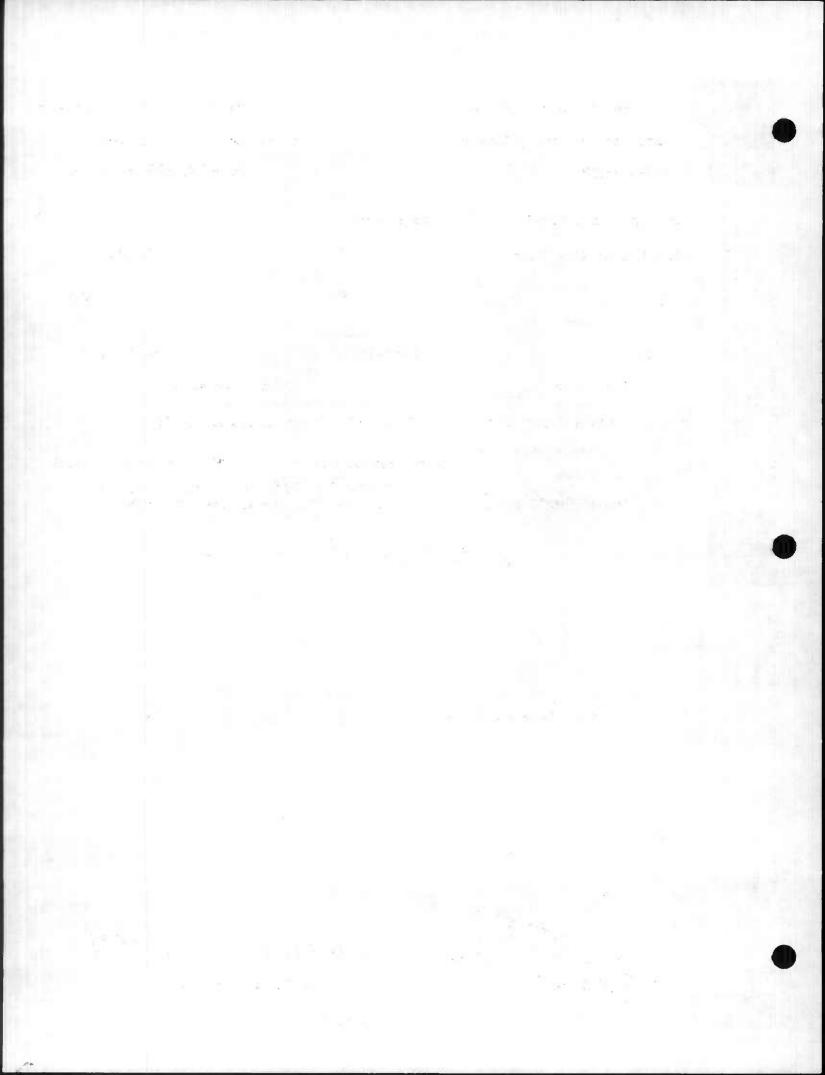
State Registrar

MAR 1 8 1999

C.

Boyd

32. Ragistrar's Signatura



State of Maryland / Department of Health and Mental Hygienen Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** March 21, 1999 21:00 Ruth Louise Chainay /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** 23240 Chestnut Oak Court Unit 1041 California St. Mary's Hours Min. 8. Dete of Birth (Month, Day, Year)
August 27, 1932 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 1 □ M 2 🛛 F Months Devs 66 220-28-5049 **Director** Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if Items 27 is marked other than "natural", or Items 23s or 23s-f show any injury or other traumatic event, the Medical Examiner must be northed once. 10c. City, Town or Location 10e Stete 10h County 10d Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race -23240 Chestnut Oak Court Unit 1041 20619 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Bleck White etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 □ Divorced Year or Detes: White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Provider Disabled Group Homes 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Irene Agnes Brown Joseph Evans Faunce 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 42848 Fairgrounds Road, Leonardtown, MD 20650 Bruce Chainay/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) All Saints Episcopal Cemetery 3/24/99 Avenue, MD 22. Name end Address of Fecility
Mattingley-Gardiner Funeral Home, P.A. 21. Signeture of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 23e. Pert1. Enter the disease, or complications that ceused the despendence of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Sudden Desta. Immediate Ceuse (Final disease or condition resulting In deeth) /Medical - minutes Examiner MONOY AVTERDISESE Examiner The law requires that the deeth certificate be executed physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last Due to (or es e consequence of) P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): use a 23b. Did tobacco use contribute to the cause of death? by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably Janknown Obstate sier open þ Division of Vital Records, 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? Chonic obstrike primi Completed 24e. Wes an eutopsy certificate has b 1 Yes ai⊠No 1 ☐ Yes 2 ☐ No director, or Attending Physician: Be 25. Wes cese referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \$\mathbb{M}\$ Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28e. Date of injury (Month, Dey Year) funeral 27. Manner of Deeth
1 Diviaturel
2 Di Accident 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

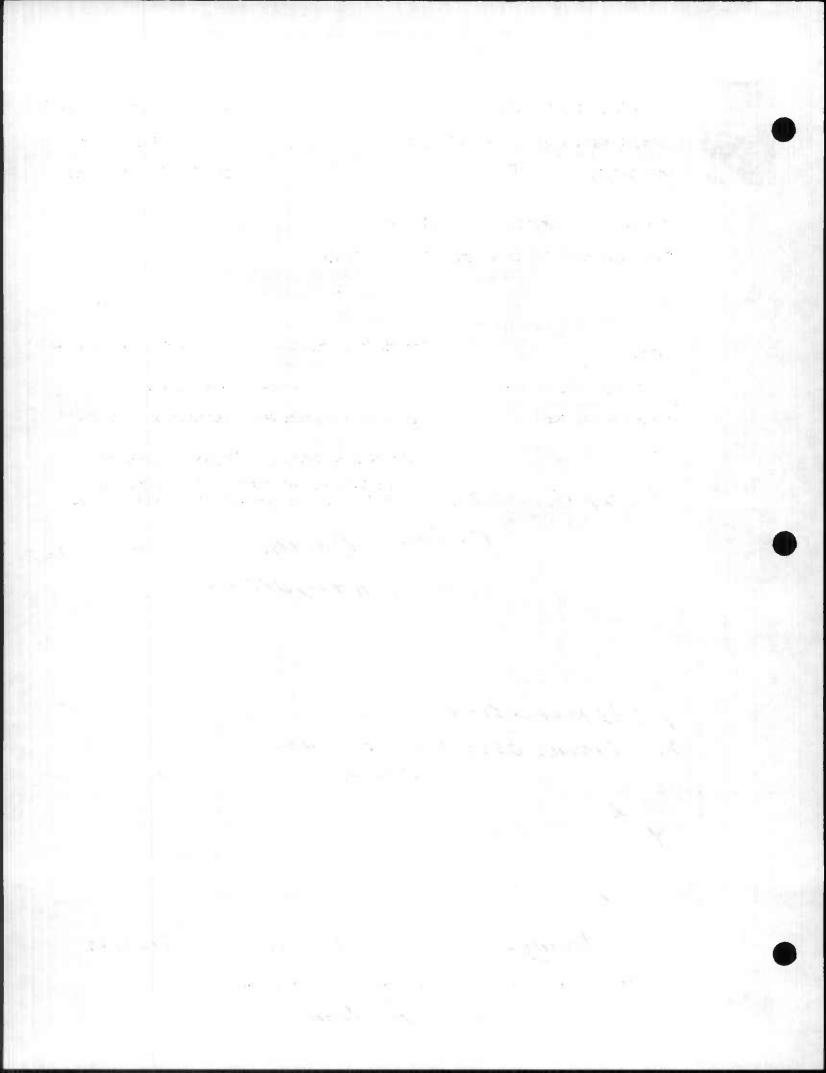
Funerel Director; A sletely filled in by the funerely investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital edical Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 0 D 36206 5/26/59. Komehl 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 12

State Registrar 31. Dete filed (Month, Dey, Year) MAR 23 1999

Kiran D. Mehta, MD 32. Registrer's Signature

Hollywood, Maryland 20636



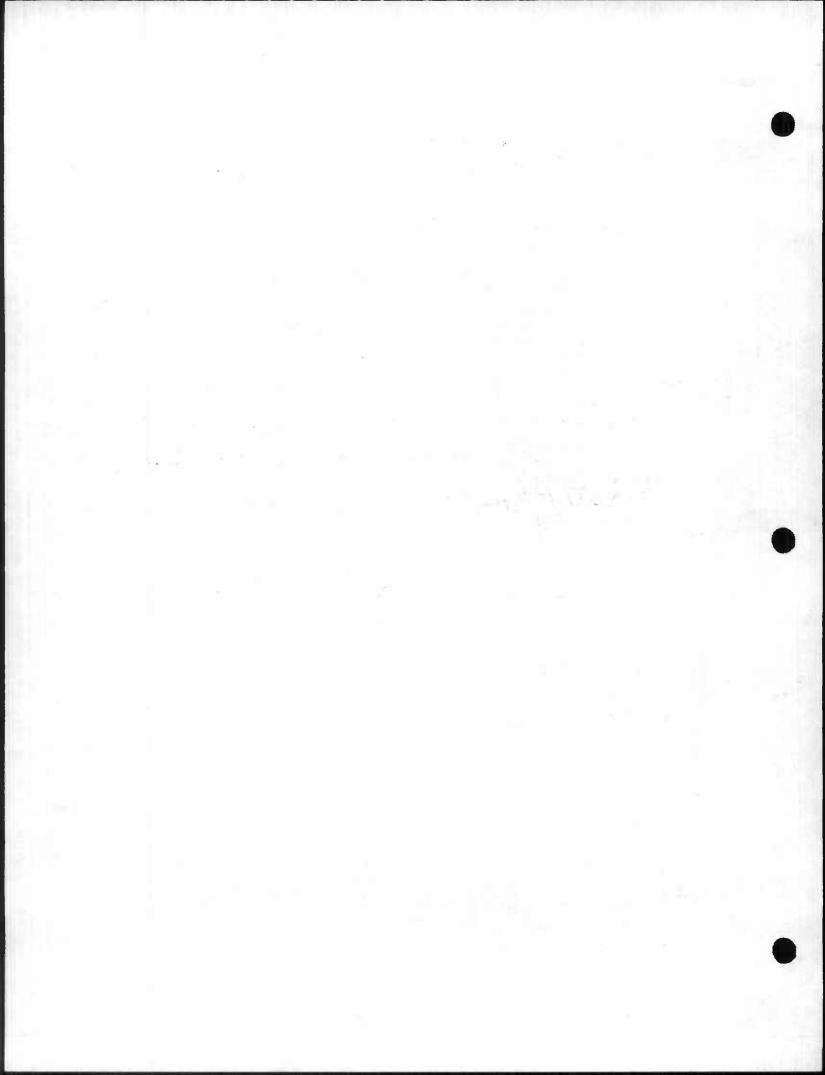
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Curry March 20, 1999 11: 10 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare MD Wicomico Birthplace (Stete or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 M 2 X F Yrs. Director JULY 9,1903 MARYLAND 214-05-8277 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show rs 23s or 28s-f shormal be notified at 1X Yes 2 No Directo MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a or 683 N. PARK DR. 21804 Funeral U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Navar Married 2 Married altimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify ğ 3 Widowed 4 □ Divorced WHITE Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiere. Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unpartment of Health and Mental I Important: If from 27 is marked of any Injury or other Be Pages 1 and 2 should be **GEORGE** SHULTZ CORA YONKER 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JENNINGS G. CURRY - SON 683 N. PARK DR. SALISBURY, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 □ Donetion 5 🛎 Other (Specify) ENTOMBMENT WICOMICO MEMORIAL PARK 3-24-99 SALISBURY, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licens 705 E. MAIN ST. CFSP BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) mes Examine Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yan 2 No 3 Probably 4 Unknown be der Records, þ 24b. Were autopsy findings available prior to complation of causa of death? should I 24a. Was an autopsy performed? Completed has 1 Yes 2 4No 1 □ Yas 2 □ No Division of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 PNetural 5 Pending Investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely lifted in by the lun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Robins William 1:5 byRy MC. 21804 MD //64 32. Registrar's Signatura

Registrar **DHMH 16 Ray 6/95**

State

31. Date filed (Month, Day, Year)

MAR 23 1999



3. Time of Death

1 Yes 2 □ No

8:20 pm

Reg. No.

Funeral Director

x 28a-f show anotified at Director 96 "natural", or items 23a or edical Examiner must be r Funeral hours after by Completed the Medical 2 filed within Hygiene. th and Mental 7 is marked of should be

Pages 1 and 2 and 2 and 2 and 2 Department of Health a Important: If Item 27 is any Injury or other than **Physician** /Medical

Baltimore, Maryland 21215-0020

Examiner

Examiner

Physician/Medical

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Completed

Be

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Certification:

edical

that the death certificate be executed attending physician and for use as the burial-tran Box 68760, 88 o. the signed by t. d be detach 4 Records, law requires should should has The certificate Physicien: this funeral After t Division or Attending death. Director: / aftar 24 hours Hospital npletaly within 2.

of Vital

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month Yee DICKERSON BLANCHE 3, 1999 MARCH 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death PRINCE GEORGES COMMUNITY HOSPITAL PRINCE GEORGES CHEVERLY If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) Deys Months Hours 1 M 2 F 63 577-44-7544 JUNE 13,1935 Usual Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County PRINCE GEORGES LANHAM 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20706 3000 BRIGHTSEAT RD., #102 U.S.A. 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Armed Forces? Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3 XWidowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th DOMESTIC N/A 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) MITTIE UNKNOWN LEE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) THERESA THORNTON -DAUGHTER 3000 BRIGHTSEAT RD., #102 LANHAM, MD 20706 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 18-99 BALTIMORE, MARYLAND ZION CEMETERY 21. Signature of Euneral Service Licenses 22. Name end Address of Facility
TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 It caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, in each line. 23a Fant. Enter the disease, or complications shock, or heart failure. List only one cause Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) RESPIRATORY FAILURE 10 min. Due to (or es e consequence of): MAI AND PNEUMOCYSTIS PNEUMONIA 1 months Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): HIV INFECTION Years Due to (or es e consequence of):

Pert II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

No No 1 Yes

1 ☐ Yes 2 X No

26. Plece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

117 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.
2 Madical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated. (Check only one) 29b. Signature anythite of certifier seen mu

Hospital:

5 Pending investigation

6 Could not be determined

29c. License number D21428

29d. Date signed (Month, Dey, Year)

nell 30 Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

DR. LINDA D. GREEN, M.D. - 3001 HOSPITAL DRIVE, CHEVERLY, MD

State Registrar 31. Dete filed (Month, Dey, Year) WAK T A 1992

25. Wes cese referred to medical exeminer?

1 Yes No

27. Manner of Deeth

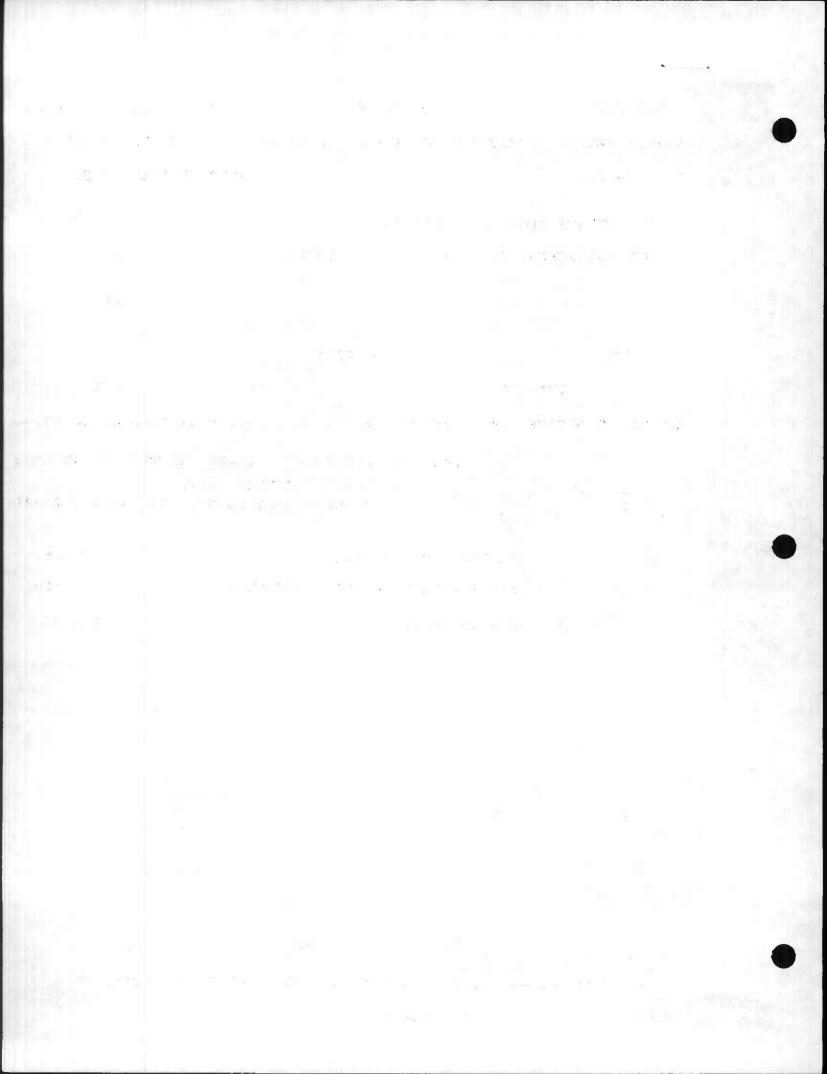
2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homleide

32. Registrer's signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Day **Physician** March 10, 1999 JOHN LANCE DATCHER 3:30PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner (Prince George 1747 Stourbridge Court Mitchellville Maryland Birthplaca (Stata or Foraign Country) If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number If Undar 1 Year 6 Sax 7. Age (In yrs. last birthday) **Funeral** Deys M 2□ F Months Director 579-52-5570 7/22/38 Washington, DC Usual Rasidance of Decedent the Meryland 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at Prince George's 1√ Yes 2 No Director MD Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours efter death with Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "---- and fully or other traument. with U.S.A. 1747 Stourbridge Court 20721 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Yas 2 No If Yes, Give Yeer or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 € No Specify: þ 3 Widowad 4 Divorcad Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Etementery/Secondary (0-12) College (1-4or 5+) Supervisor Federal Government 12th Grade
17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be John A. Datcher Roberta Offus 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Typa, Print) Wanda A. Datcher (daughter) 1747 Stourbridge Court Mitchellville, MD 20721 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - Clfy or Town, Stata 1 N Buriai 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) 3/16/99 Lincoln Memorial Cem. Suitland, MD 22. Name end Addrass of Facility 21. Signature of Funaral Sarvice Licansae ROLLINS FUNERAL HOME, INC. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrast, approximate interval abundance.

Approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, such as cardiac or raspiretory arrast, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate interval abundance of dying, approximate i **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in deeth) ulmonai Examiner Examiner 3 weeks Vein The law requires that the death certificate be executed physician end s the burief-transit Sequantially list conditions, if any, laeding to immediata causa. Entar Undarlying Cause (Disaasa or injury that initieted events resulting in death) Lest year Division of Vital Records, P.O. Box 68760, Physician/Medical 89 USB signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Pert i. 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate has b 1 ☐ Yes 2 1 No 1 ☐ Yas 2 ☑ No or Attending Physician: 25. Was casa refarrad to medical Be 26. Placa of Daath (Check only ona) Othar: 4☐ Nursing Homa 5 (Residence 8 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Yaar) 28b. Tima of After 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant after deet 6 Could not be determined 3 Suicida 28a. Plece of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) n 24 hours after ne Funeral Direct nietely filled in b 4 Homicida 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, daath occurred at tha tima, data and piace, and due to tha causa(s) and mannar es steted. edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end piece, end due to the causa(s) and manner stated.

29c. License number

0051714

2401 Research Blvd. Suite 102 Rockville, MD

29d. Data signad (Month, Day, Year)

March, 16, 1999

Registrar

29b. Signetpra and titla of certifier

rullion

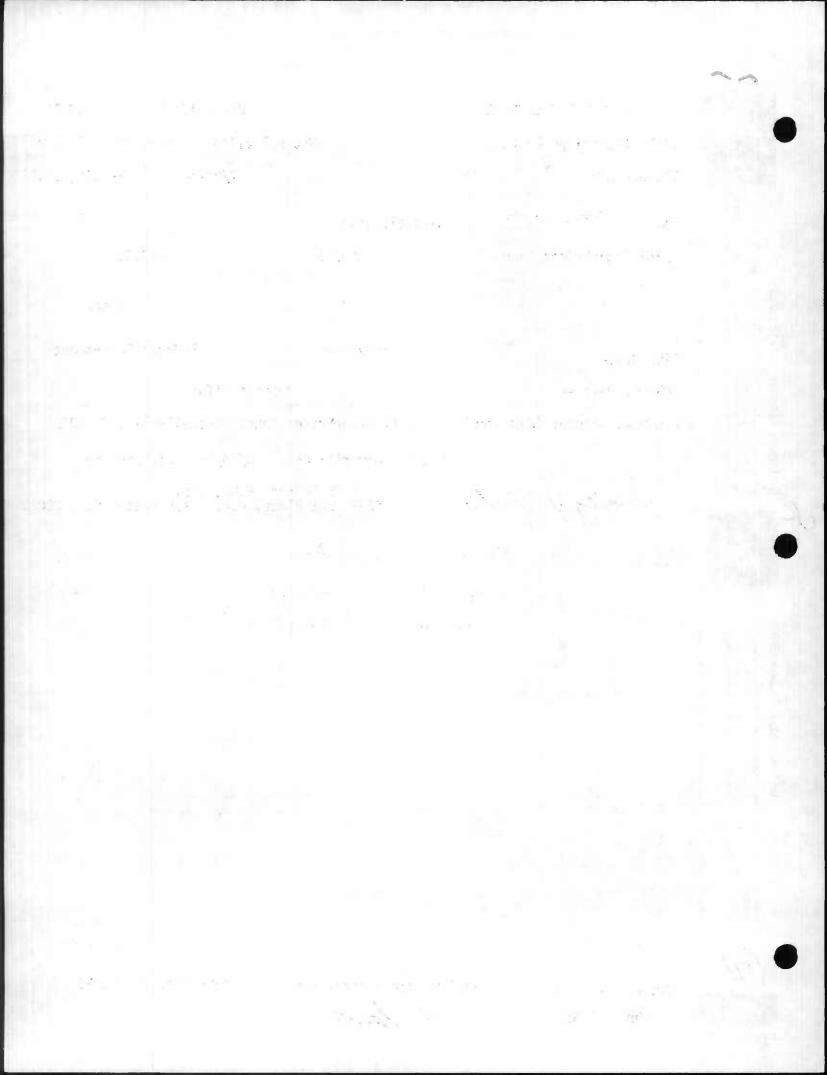
Dr. Jatinder Sekon 31. Dete filed (Month, Day, Year)

MAR 1 7 1999

MD

32. Registrar's Signature

30. Name and eddrass of person who complated causa of daath (Item 23e) (Type, Print)



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- 3		0	C I	1
- 1			1 .	4

			Cel	lilicale of	Dealli	Re	g, l
Physician /Medica	TACHATAN					2. Data of Death Month MARCH	1
Examine	A. P. Mrs. Adv. M. M. L. L. L. L. L. L. L. L. L. L. L. L. L.	tion, giva street and n	umber)		4b. City, Town,	or Location of Death	4
	HOLY CROSS HO	OSPITAL			SILVER	SPRING	1
Funeral	5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaa Months Day		irs. 8. Data of Birth (Month, Day,	Yes

or 288-7

Norrs 23a 8

permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked or any injury or other traumatic eve

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner Physician/Medicai Completed by should be or Attending Physician: director After this

P.O. Box 68760,

Records.

Division of Vital

25. Was cesa ratarred to medical axaminar? Medicai Certification: To 1 Yas 2 No 27. Manner of Death To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 2 Accidant 3 Suicida 4 Homicida 29a. Cartifiar 29b. Signatura and titla of cartifiar

31. Data tiled (Month, Day, Year)
MAR 1 8 1999 State Registrar

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) KANNARKAT.MD 3. Registrar's Signatura

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify)

28b Time of

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Data of Injury (Month, Day Year)

zune disorder

5 Panding invastigation

6 Could not be datarmined

Hospital:

8201

3. Tima of Death Yaar 1999 8:15AM 4c. County of Death MONTGOMERY 9. Birthplaca (Stata or Foreign JAMAICA OCT. 28, 212-21-1941 Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Vas 2 □ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Coda UNITED STATES 13835 CASTLE BLVD. APT. 23 20904 Funerai RESIDENCE 14. Race - Amarica Race - Amarican Indian. Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Yas 2 No Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 3YRS. STUDENT PRIVATE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be 2 MARGARET SIMON GERALD DIXON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Nama of cematary, crematory or other place) 23, SILVER SPRING, GERALD V. DIXON (FATHER) 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from State Data 20c. Location - City or Town, Stata 4 Donation - Donation (Specify) FAMILY CEMETERY 3/19/99 CLARENDON, VERE 22. Nama and Addrass of Facility 21. Signature of Fugeral Service Mcenses JOHNSON & JENKINS, INC. 716 KENNEDY ST. N.W., W.D.C. hal carsed the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, on each line. Approximata Interval Batween Onset and Death Immediata Causa (Final temic lupus Enythematosis
Dua to (or as a consequence ot): Systemic disaasa or condition rasulting in death) End Stage Renal Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of)

> 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of causa of death?

1 Yas 2 No

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only ona)

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Dascribe how injury occurred

28c. Injury at Work?

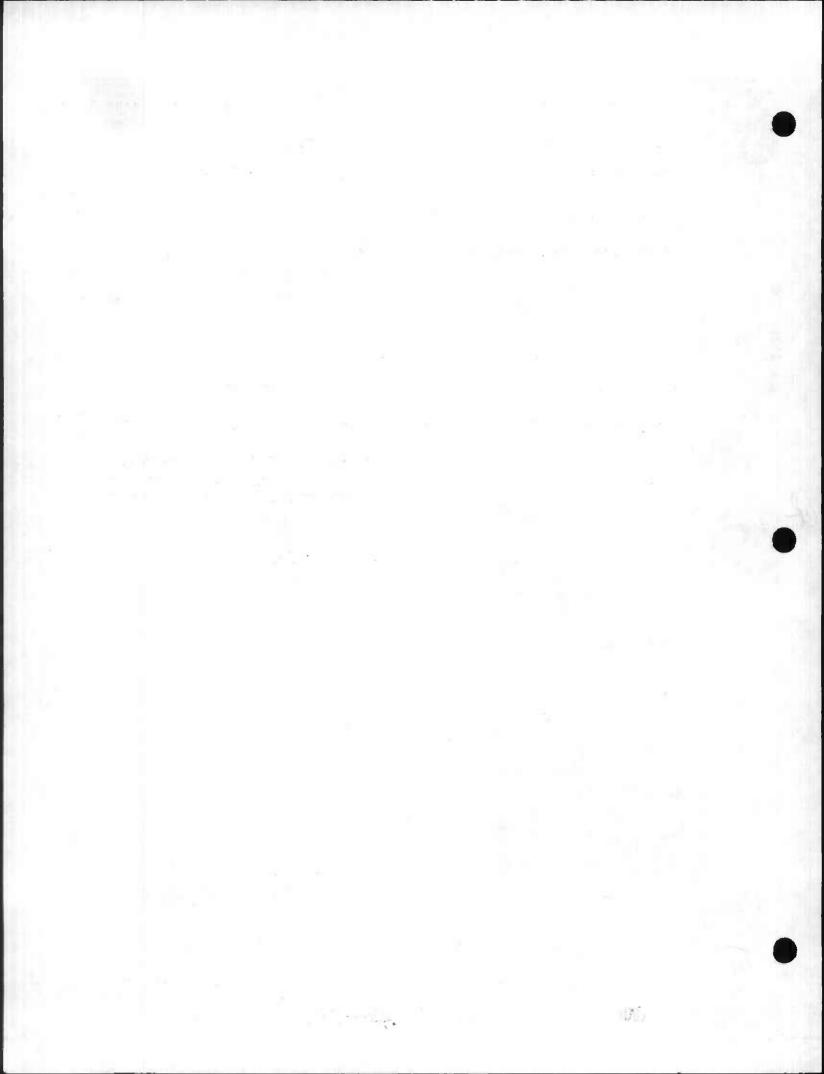
1 Yas 2 No 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

29d. Data signed (Month, Day, Year) 29c. Licanse number D-20062

16 St. SILVER SPRING MD 20910



Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours after neal of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural; or the Inty or other traumate avent, Its Madical Examine.

permit. Page Depertment of important: If any Injury or

Physician /Medicai

Examiner

physician end s the buriel-trensit

Baltimore, Maryland 21215-0020

the Marylend

deeth with

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Yae **Physician** George William Davidson March 07, 7:35 P.M. 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth **Examiner** Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number Hours Months Yrs. 57850342 LYNKHBURG VA Usuel Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No GEDRGE'S CCOKEEK Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2060 Funeral 14. Race - American Indien, Bleck, White, etc. Wes Decedent Ever in U.S. Armed Forcas? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Naver Married 1□ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DWNER TYLIST 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be unknown DAVIDSON 2 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAVIDSON CLOKEEK HELEN 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cremation 3 Removel from State 13 LRREC 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 57, 0 814 FRANKLIN ALEXY VA, 22314 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death Immediete Ceuse (Finel Congestive Heart Failure diseese or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Inspection 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 No 1 | Inpatient 2 | XER/Outpetient 3 | DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation Injury 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

The law requires that the deeth certificate be executed P.O. Box 68760, ettending pl been signed by the should be detached Division of Vital Records, is certificate has be director, page 2 s Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice funerei _ filled



31. Date filed (Month, Day, Year)

29a. Certifier

296, Signatur

(Check only one)

Medical

State

Registrar

MAR 1 7 1999

SMIALEK, M.D.

destin of certific

32 Registrer's Signeture

h who completed cause of deeth (Item 23e) (Type, Print)

1 Curtifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

dical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, data end piece, end due to the cause(s)

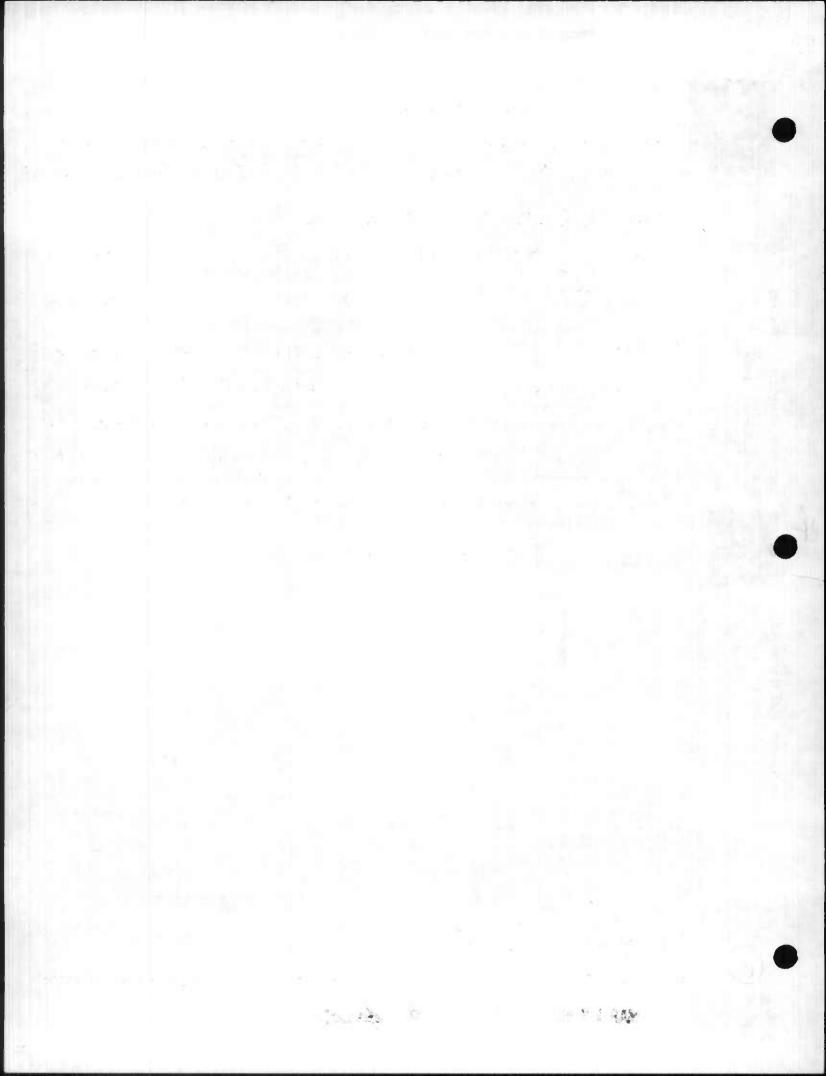
O.C.M.E.

29c. Licansa number

29d. Data signed (Month, Dey, Year)

MARCH 9, 1999

111 Penn Street, Baltimore, Maryland 21201



		Ce	ertificat	eor	Jeath			leg. No.		La Time da	_
Decedent's Name (First, Middle, Last,)					1	2. Date of Dea Month	Day	Year	3. Time of Deeth	
ELIZABET 4a Facility Name (If not institution, give				4	b. City. Tow	n. or Loc	March atlon of Deeth	14, 19		9:10 AM	_
199 ROLLINS AVENU		n			Rockvi			Montg			
5. Social Security Number 6. Sec	x 7. Age (In	yrs. last birthday	() If Under Months	r 1 Year Days	If Under 2		8. Date of Birth (Month, Dev			lace (State or Foreig	n
579-28-1343	™ 2 ¹²⁴ 80	Yrs.	Working .	July	1100.10		Feb. 2	7,1919	Wash.	,DC	
Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or I	Location						1	0d. Inside City Limits	3
Maryland Montgomen	ry 1	Rockvill	Le							XXYes 2 No)
10e. Street and Number			10f. Zip	Code				10g. Citizen of V	What Coun	ntry?	
199 Rollins Avenue	-		208					US			
11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13	I. Was Deced If Yes, spe-	_	ispanic Orig en, Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	etc.	
15. Decedent's Edu		16e. Dec	edent's Usua e kind of wo	ai Occupa	ation	of workin	0	16b. Kind of Bu			
(Specify only highest gred	College (1-4or 5+)	life.	DO NOT u	ise retired	dring most	Of WORKIN	9				
		La	undry	Sup				Private Maiden Suman		ustry	
17. Father's Neme (First, Middle, Last) James M. McCa	ard								,3/		
19a. Informent's Neme/Relationship (Ty		19b. Ma	iling Address	s (Street			Route Numbe	r, City or Town,	State, Zip	Code)	-
Ralph Dent/husbar	nd	199	Rolli:	ns A	venue	Apt.	820 R	ockvill	e,Md.	20852	
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		0b. Place of Disposer cometery, cr	position (Nar ematory or o	me of other plac	ce)		Date	20c. Location -	City or To	own, State	
4 Donation 5 Other (Specify)		Lincoln					19/99	Suitlan	d,Mar	ryland	
21. Signature of Funeral Service Licens	99	F	22. Name er	nd Addres	ss of Facility Funera	1 Hc	me,Inc				
N.y. Jr	1 fur	3	189 Rh						ab I	C 20001	
snock, or neart failure. List only of	ications that caused the ne ceuse on each line.	death. Do not e	nter the mod	de of dyin	g, such es d	ardiac or	respiratory ar	rest,	SH • JI	Approximete Intervel Between Onset and Death	
Immediate Cause /Final	a. Cerebrova	scular to (or es a cons	equence of):	de of dyin	g, such es c	cardiac or	respiratory ar	w wa		Approximete Intervel Between	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Physician Month Dev March 13, 1999 Mildred 5:19 AM Deutsch /Medical 4e. Fecility Neme (If not institution, give street end number) 4b City Town or Location of Death 4c. County of Deeth Examiner 4712 Manheim Ave. Beltsville Prince George's If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Birthplece (State or Foreign Country) 1 M XXF Yrs. Director 88 579-48-2094 Jan. 7,1911 Rochester, NY Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location must be nothed at 10d. Inside City Limits Director 1√Yes 2 No Maryland Prince George's Beltsville 10e. Street and Number 10f Zip Code 10g. Citizen of Whet Country? death with 4712 Manheim Ave. 20705 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: r than "natural", or items 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Admin. Assistant Federal Government traumatic event. Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Heath and Mental Hy, Important: If Item 27 is marked other any injury or other traumatic event, 900.8. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Stiller Jacob Julia Dunn 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alan Deutsch / Son 5501 24th. Street North, Arlington, VA 22205 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete March 4 Donetlon 5 Other (Specify) King David Cemetery 14, 1999 Falls Church, VA 21. Signature of Fungs Service D 22. Name end Address of Fecility Stein Hebrew Memorial Funeral Home 23e. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

ADI Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Metastatic Malignant Melanoma disease or condition resulting in deeth) 4 months Examiner Due to (or es e consequence of): The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Last Due to (or es e consequence of): P.O. Box 68760, ettending physician Physician/Medical Due to (or es e consequença of) use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ Completed 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? certificate has 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) P After this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No Director: A in by the f 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 within 24 hours a
To the Funeral E
completely filled TS Certifying Physician; to the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner as stated.

In the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and 29c. License number 29d. Date signed (Month, Dey, Year) D 08754 March 15, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Thomas A. Bensinger, MD 7525 Greenway Dr., Greenbelt, MD 20770 3 Registrar's Signeture 31. Dete filed (Month, Day, Year) State MAR 1 6 1999 Registrar Sports

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0934 Daniels Joseph MIMICH /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner University MEdicina OF MARYIMA Baltimore City Baltimore 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 → M 2 □ F Months Days Hours Yrs June 9, 1942 North Carolina 240 68 8902 Usual Residence of Decedani 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No Potomac Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 USA 13112 Brushwood Way Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Manager (Federal Systems Branch) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy McLaurin Unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) Potomac, MD 20854 13112 Brushwood Way Silvia C. Daniels (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Spacify) Entombment Cedar Hill Cemetery 3 - 19Suitland, Maryland 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4 C/Duscoe-lone 4308 Suitland Road 20746 Suitland, MD 23a. Part. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Deeth Immediate Cause (Finel CARDINZ ARRHYTHMIA disease or condition resulting in death) Due to (or as a consequence of): Examiner DISENSE HRTEROSCLEROTIC HEXALT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last HOUSIC Eure phalopathi Physician/Medical Due to (or as a consequanca of) Part II. Other eignificant conditions contributing to daath but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy periormed? Completed 2D No 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? 1 √ es 2 □ No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 1 Unpatient 2 ER/Outpatlent 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturai 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signad (Month, Day, Year) 00 1346 ames P. 6.

39. Name of eddress of person who consisted cause of death (Item 23a) (Type, Print)

THUS FLYNNUS THOUSE STEINETY HOSPITAL THAME. BILS CHARLES ST 21230

3. Registrar's Signature

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madroal Examiner must be notified at

the Marylend

with

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumetic.

Physician /Medical

Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Physician 19th 1999 March 3110 BM Marian B. Dorse /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Carroll County Cas Carrott 7. Age (In yrs. last birthday) areneral Westwarter If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🖾 F Yrs Director 219 36 0567 88 April 17, 1910 Md. Usual Residenca of Decedent the Marylend 10b. County 10a State 10c. City, Town or Location 10d. inside City Limits must be notified at Md. Carroll 1 Yes 2000 Westminster Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code with 250 St. Luke Circle 21158 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Race - American Indien, Black, White, etc. than "naturel", or items the Medical Exerviors ma 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: White Specify: g 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Hygiena. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumeme) Peges 1 and 2 should be filt ment of Health and Mental Hant: If them 27 is marked oth jury or other traumatic event Be Eugene Clifton Berry Marianne Brown 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nellie-Polk Peiffer (daughter) 7501 Gaither Rd. Sykesville, Md. 21784 20b. Place of Disposition (Neme of cemetary, crametory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Slete Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or Springfield Cemetery 3/22/99 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarel Service Licenses 22 Nama and Address of Facility Sykesville, Md. 21784 Haight Funeral Home & Chaper

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart felture. List only one cause on each line. Haight Funeral Home & Chapel P.O.Box 195 Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Acute Myocendte disease or condition resulting in death) Examiner Due to (or as a consequence ot): Examiner Menury the death certificate be executed physician and the buriel-transit Sequentially list conditions. if any, leeding to immediate cause. Entar Underlying Cause (Disaasa or injury that initieted events resulting in daath) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): as t use a 0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes DE No 3 Probably 4 Unknown Division of Vital Records, þ The law requires 24b. Ware autopsy findings available prior to completion of cause of deeth? been si 24a. Was an autopsy Completed Is certificata has director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of injury (Month, Dey Year) 27. Manner of Daath 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: After or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu death. 2 Accidant 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homlcida an: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physic 29a. Certifier edicai (Check only onel 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Meuch 1 arch Lago 1237949 30. Name and address of perso 3a) (Type, Print)

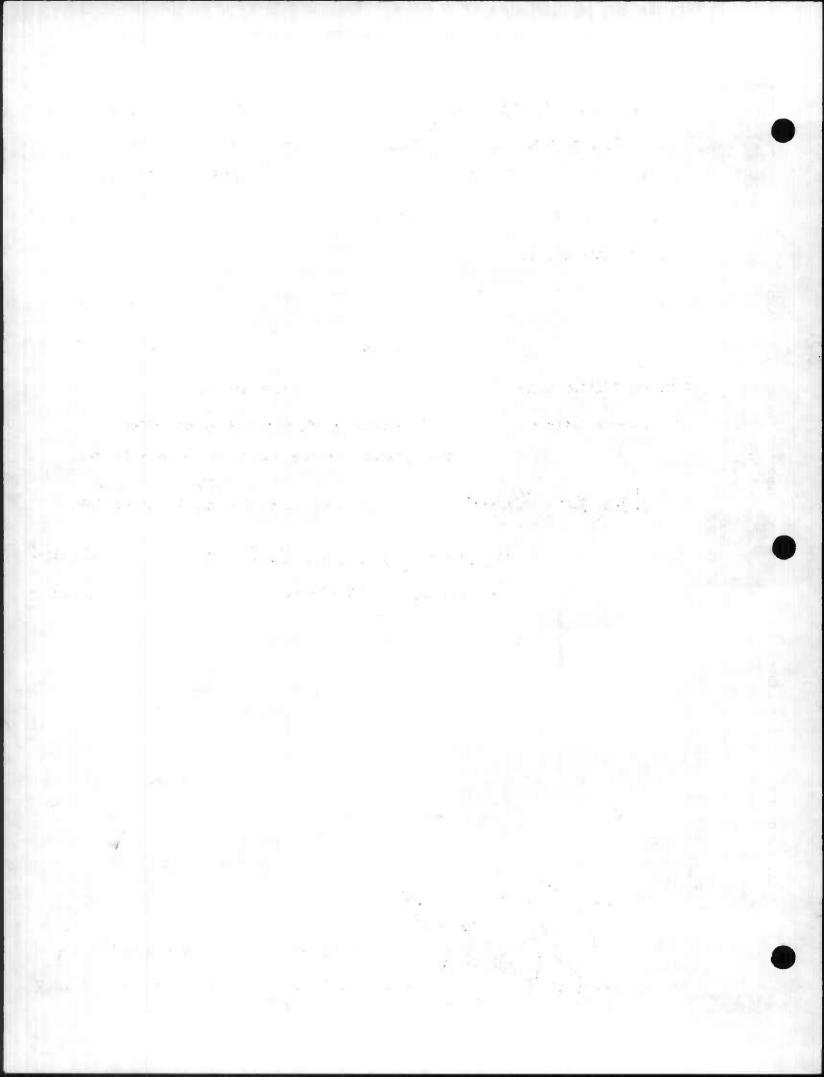
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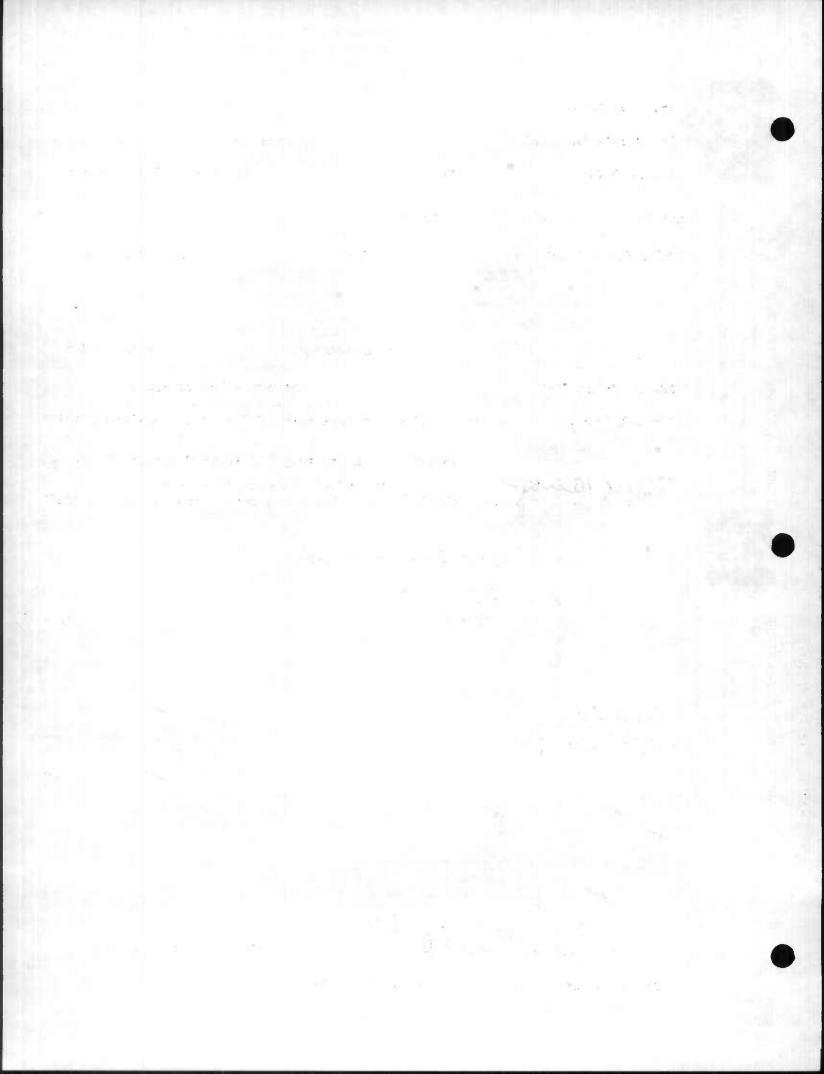
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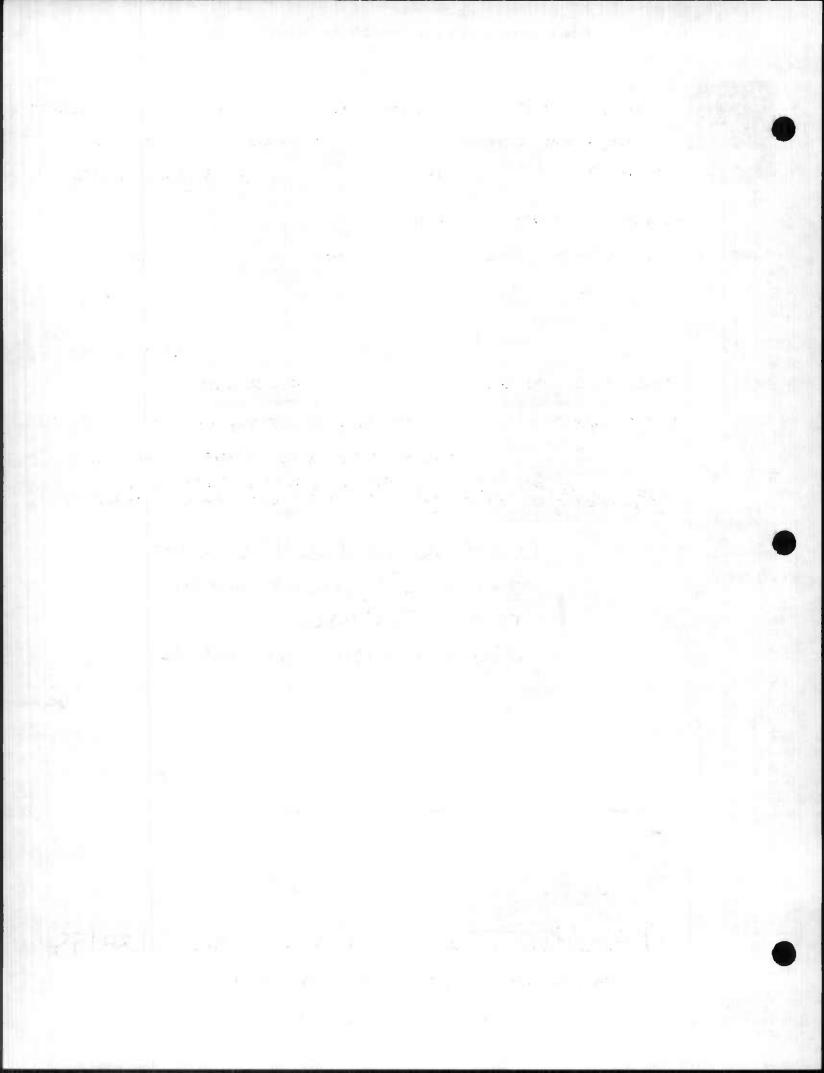
			Certifica	ate of De	ath	Reg	No.	1 0	000
Dhusisian	1. Decedent's Name (First, Middla, Last,)			2.	Date of Death Month	Day	Year	3. Time of Deeth
Physician /Medical	Erva May Davis				Ma	arch 13,	1999	(6:05 a.m.
Examiner	4a Facility Name (If not institution, give	street and number)		4b. C	city, Town, or Locat	ion of Death	4c. County	of Death	
	St. Mary's Hospit	al		Lec	onardtown		St.	Mary'	S
uneral	5. Social Security Number 6. Sa:	x 7. Age (In yrs.	last birthday) If Und		Under 24 Hrs. 8.	Date of Birth (Month, Day, Y	par)	9. Birthpla	ca (State or Foreign
ector	216-38-5482 Usual Rasidence of Decedent	93 P 93	Yrs.	o Days		rch 10,		Mary	
or 28s-f show e notified at Director	10a. Stata 10b. County	10c. Ci	ty, Town or Location					100	d. Inside City Limits
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rec Per	10e. Street and Number			Zip Code		10g	. Citizen of V	What Country	y?
10	25720 Budds Creek	Road	2	0621		11	nited	Stato	C
or mutt		12. Wes Decedent Ever in U			nlc Origin? (Specif lexican, Puerto Ric			e - Americer	_
by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ■ Widowed 4 ☐ Divorced	Armed Forcas? 1 ☐ Yes 2 ■ No If Yes, Give		pecify Cuban, N		an, etc.)	Specify		
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Completed	15. Decedent's Edu (Specify only highast grad		16a. Decedent's Us (Giva kind of	work done durin	ng most of working	16	b. Kind of Bu	usiness/Indu	istry
ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	tician			Bear	uty Sa	10p
S	7		Deau		*****				1011
BeC	17. Father's Name (First, Middla, Last)				Mother's Name (F				
10	Edward Johns Fish			(Catharine	Eudora	Sanne	er	
-	19a. Informant's Name/Relationship (Ty				Number or Rural P				
	Michael Birch,	Nephew	5533 New		oad, Whit	e Hall,	Mary.	Land 2	1161
6	20a. Mathod of Disposition		Place of Disposition (Acemetery, crematory of	vama of or other place)		Date 20	c. Location -	City or Tow	m, State
ry or	1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		rist Church	Cemete	erv 3/1	6/99 Ch	antico	o. Mar	vland
ny injury or ncs.	24-Signatule of Funeral Sappice Licens		22. Name	and Address of	f Facility				<i>J</i>
8 8	mu Bu	150			Funeral				
		nkenship, MOC	10857 2295	55 Holly	ywood Roa	d, Leon	ardto		20650 Approximate
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne ceuse on each line.	in. Do not enter the m	loue of dynig, s	ucit as caldiac of f	espiratory arrest	•		ntervel Between Onset and Death
cian	Immediate Course (Final		,		c				A A
dical iner	Immediate Causa (Final disease or condition resulting in death)	a multile	bar one	umon	is-				Iweek
	resulting in death)	Due to (or as a consequence of	of):					1
the bunel-transit		Agoira	tion					15	mounts
Examiner	Sequentially list conditions,	Due to (or es a consequence o	of):					
ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	STACK	se-					13	-6 mouth
edicai	Cause (Disease or Injury that Initiated evants resulting in death) Last	Due to (c	or as a consequence of	of):				1	
3 0									
2		d						1	
Icia	Pert II. Other algnificant conditions cor	ntributing to death but not res	sulting in the underlying	a ceuse aiven ir	n Pert I.	23b. Did toba	cco use co	ntribute to t	the cause of death
by Physician/N	A _AC	g to down but not les	g the didenyin	a accao Aisou II			2 PNo		ably 4 Unknow
Y	- Ulmenter -					1 108	SALINO	0071000	J., J. J.
Completed by Physician/N	1 Ala (1 1-1 .M)	A				24a. Was an		24b. Wer	e autopsy findings
ete	- Alked Februs	elean				performe		avai	lable prior to
Zez H									eeth?
S O						1 ☐ Yes	2 10 No	1 🗆	Yes 20 No
Be ag	25. Was cese referred to medical examiner?	L= %- L			B. Place of Death (6	Check only one)			
To dire	1 ☐ Yes 2 No				4 ☐ Nursing Home				
	27. Manner of Death 1 Naturel 5 ☐ Pending	28a. Dale of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	286	d. Describe how	Injury occur	red	
atic	2 Accident Investigation		М		2 □ No				
iffic	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, fact	tory, office	281	Location (Stre	et and Numb	per or Rural	Route Number,
e L	- LI TOTHIGOS	ounding, etc. (Special	'97			July or Town,	2.010)		
edical Certification:	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge daath occurre	ed at tha tima, o	date and place, and	d due to the cau	se(s) and ma	anner as sta	ited.
dic dic	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or Investigati	ion, In my opinio	on, death occurred	at the time, date	and plece,	end due to t	the ceuse(s)
Me	29b. Signature end title of out tiget	M)	1/1/100	29s, Licanse nu	ımber	290	. Date signe	d (Month, D	ay, Year)
U	1/1/1/	DX LA	Mel	1 00	52196		7 -15	Ow	,
	4/100	or piec	7	000	1710		3-13	79-	
	30. Name end eddress of person who co	empleted cafuse of death (Item	m 23a) (Type, Print)						
				2000					
	Dr. J. Scott Ti		lywood, Md	. 20636					

ERVA FISH DAVIS



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	d Sanda Na Na Maria de de de de	- Al	Ce		Doutin	2. Dete of Dee	eg. No.	D. The out Death
Physician	Decedent's Neme (First, Middle, Lateral					Month		3. Time of Deeth
/Medical		Adolph	Denke	r Jr.			21, 1999	5:20 PM
Examiner	4a Fecility Neme (If not institution, give	a street and number)			4b. City, Town, or L	ocation of Death	4c. County of I	Deeth
	St. Mary's Nurs	ing Center			Leonardt			lary's
Funeral	Sociel Security Number 6. S	ax 7. Age (In yi	rs. last birthday)	If Undar 1 Yeer Months Devs	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey	Year) 9.	Birthplece (State or Foreign Country)
Director	216-16-3153	MW 201	77 Yrs.			April	4,1921	Maryland
Du »	Usuel Residence of Decedent 10a. Stata 10b. County	100	City, Town or Lo	nastian				10d. Insida City Limits
ehon ehon								1 ☐ Yes 2 🛣 No
death with the Manyland ms 23a or 28s-f show rount be notified at neral Director	Maryland St. Ma:	ry's	Lexingt	on Park				
or 2	10e. Street end Number			10f. Zip Code		1	0g. Citizen of Whe	t Country?
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	11. Maritel Stetus	12. Wes Decedent Ever in Armed Forces?	U,S. 13.	Wes Decedent of I If Yes, specify Cub	Hispenic Origin? (Span, Mexican, Puart	pecify Yes or No- p Rican, etc.)		American Indien, White, atc.
within 72 hours after death with the Manylan ena. than "natural", or items 23a or 28a-f ehow he Madical Exercises must be incitited at empleted by Funeral Director	1 Never Merried 2 X Married	1 X Yes 2 □ No If Yes, Give		1□Yes 25 No			Specify:	TeTlo i + o
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1 and Haalth am 27 other tr	Ruth M. Denker/W		4675	5 E. Mar.	shall Bly			rk, MD 20653
of H f har	20e. Method of Disposition 1 Burial 2 □ Cramation 3 □		cemetery, crea	osition (Name of metory or other ple	ice)	Date	20c. Location - Cit	y or Town, Stete
permit. Pages Department of important: If he any Injury or o	4 ☐ Donetion 5 ☐ Other (Specifi	y) S	olamans M	ethodist 0	ametery	3/24/99	Solomon	s, MD
permit. Departmitimportal any Inju	21. Signeture of uneral Service Licer	isee /	22	2. Name and Addr	ess of Fecility	F	al Home	D A
88 2 8	Who was PA	en the De		_	y-Gardin			
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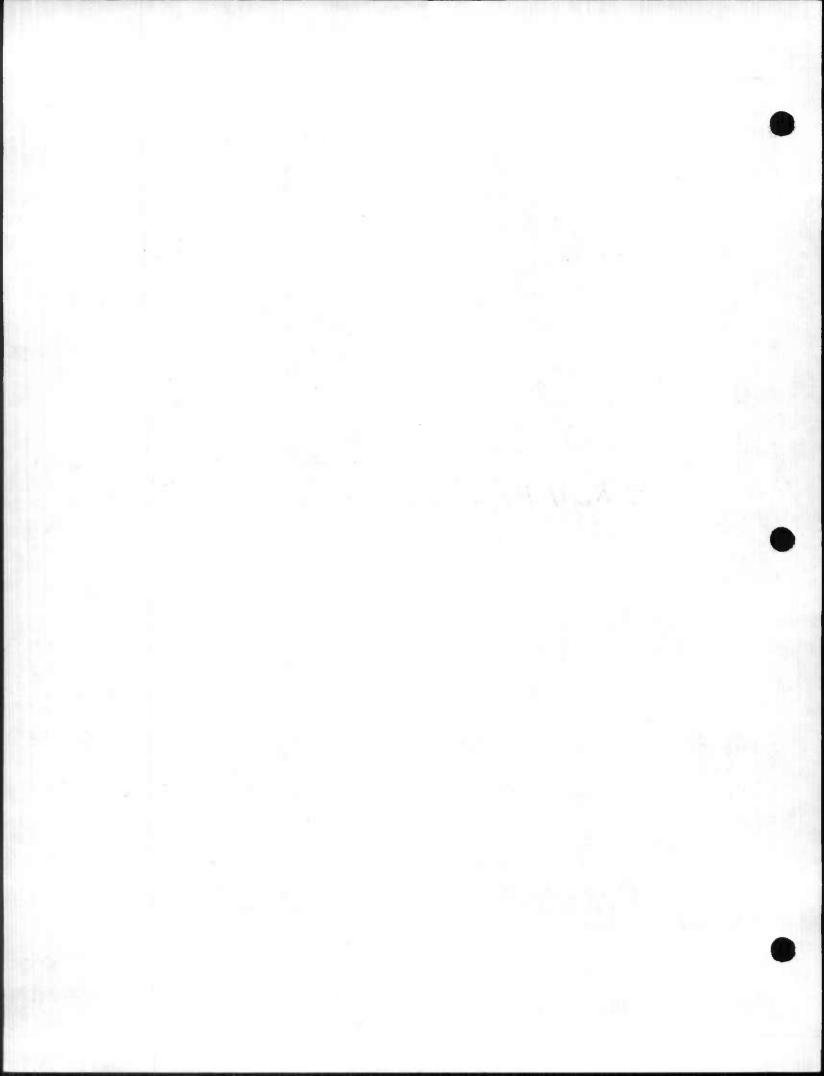
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

					Certific	ate of	Death		Reg. No.	108	58
		1. Decedent's Neme (First, Middle, Last)	7.5	11111			2. Dete of D	eath		a ot Death
	hysician /Madical	Virgie	NE	LL		Dis	haroon	March	21, 1999	Year 4:00) PM
W	/Medical Examiner	4e Facility Neme (If not institution, give						or Location of Dea		ot Deeth	
		Salisbury Center:	Genesis El	derCare	3		Salisbu	ry, MD	Wicomi	co	
	neral ector	214-28-3212	7. Age (In yrs. last birtl	hday) If Un Mont	hs Days		Hrs. 8. Dete of Bi (Month, D SEPT . 5	irth ay, Year) , 1918	Birthplace (Stet Country) ALABAMA	e or Foreign
20		Usuel Residence of Decedent 10a. Stete 10b. County	1.	0c. City, Town	or Location					10d Incide	City Limits
e Maryle	or 288-1 shows the modified at	MARYLAND WICOMICO			SVILL	E					es 20 No
ath with th	ust be no	10e. Street and Number 9049 GUMBORO RD.				Zip Code 218			U.S.A.		
21215-0020 d within 72 hours after death with the Maryland jiena.	Landon 234 of 284-9 show	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	er in U,S.		specify Cut specify No		? (Specify Yes or N uerto Rican, etc.)	o- 14. Race Bleck Specify:	e - American Indian, k, White, etc.	
2 P	t, the Mades Es.	15. Decedent's Edu (Specify only highest grad		16a. l	Decedent's U	Isuel Occu	pation	working	16b. Kind of Bu	siness/Industry	
21 e ë	man mple	Elementary/Secondery (0-12)	College (1-4or 5+)				during most of ed)	Working			
A BB	C T	12		TI	EACHER	'S AI				SCHOOLS	
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arylan should be	To	WALTER L. SANF	ORD				MATTIE	JANE	MOONEY		
2 she		19e. Intorment's Neme/Relationship (T)	rpe, Print)	19b.	Mailing Adda	ess (Stree	t end Number o	Rural Route Num	ber, City or Town,	State, Zip Code)	
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O 85	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20a. Method of Disposition			r, cremetory	or other ple		Date		City or Town, State	
III.	any injury	21. Signature of Furnish Service Licens		PITIS	VILLE		ess of Fecility	3-25-99		LLE, MARY	LAND
	and de de de de de de de de de de de de de	1 R. Keut	A home	CFS	77			HOME, INC.		MAIN ST.	21804
L	burial-transit auju	resulting in death) Sequentially list conditions.	o	e to (or as e c	onsequence	of):		leo USE			
tificate	as the bur	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thei initiated events resulting in death) Last	Du	e to (or es a co	onsequence	of):					
	d for	Pert II. Other algnificant conditions cor	atributing to deeth but r	not resulting in	the underhir	o cauca o	iven in Part I	23h Dk	I tobacco usa con	tribute to the caus	on of death?
that the C	by Physician/M	Denevin)	iot resulting in	are underlyn	ig cause g	17011 11 17 11 1.		/	3 □ Probably 4	
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T e	page 2	7	myrene	9				10	Yes 2 No	1 ☐ Yes 2	No
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nding Physics		27. Menner of Death 1. Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Y	(ear) 28b. Ti	ime of jury M	28c. Inju Wo		-	how injury occurre		
To the Hospital or Attending Pt within 24 hours after death.	led in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, fen	m, street, fed	tory, office			(Street end Number own, Stele)	er or Rurel Route N	lumber,
Hospit 124 hour	pletely fille	29e. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of ner: On the besis of example and menner steller	eminetion end	deeth occuri /or investiget	red et the t tion, in my	ime, dete and pl opinion, deeth o	ece, end due to the eccurred at the time	cause(s) and me , date and pleca, a	nner es stated. and due to the caus	ie(s)
To the	Wedwood	29b. Signetura and little of to milion				29c. Licen	se number		29d. Date signed	Month, Day, Yea	7)
		· 6/11	ler				-398	13	3/7	2/99	/
	10	30. Name and address of person who co	empleted cause of deat	th (Item 23a) (1	Type, Print)		- 1		7	-1 -1	
	0	Michael R. Atkins,				7 02	Calia	Oliver MD	21004		
	State	31. Dete filed (Manth, Day, Year)	32 Registrer's	Signeture	TT CTIME?	y Dr.	, Salls	oury, MD	21804		
В	egistrar	31. Dete filed (Manth Day, Year) MAR 23 199	19 Sene	wa	4	10-	11				

DHMH 16 Ray 6/95



Funeral

Director

28a-f show

ò items 23a

traumatic event, the Madical Examiner must be notified at

"natural", or

d 2 should be filed within 72 th end Mentel Hygiene.

Pages 1 and 2 should be

Depertment of Health e Important: If item 27 is any Injury or other tra

Physician

/Medical

Examiner

ettending physician and for use es the bunel-transit

signed t

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

the Marylend

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

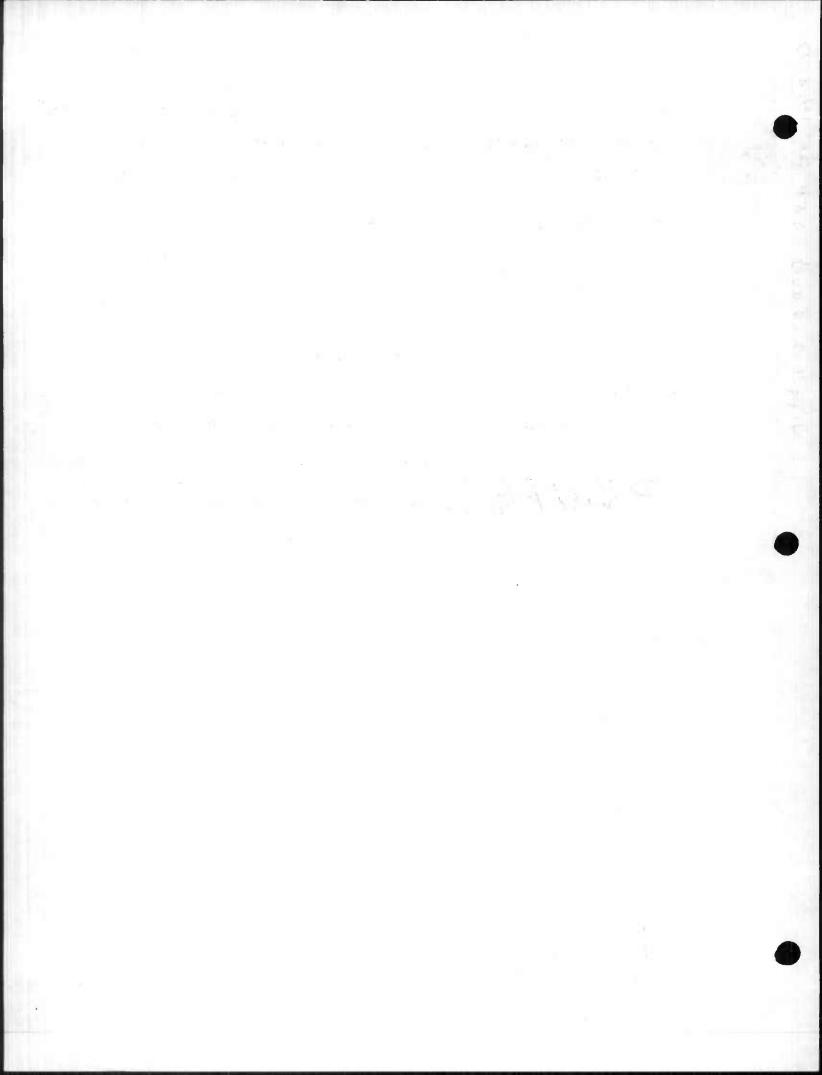
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day 1999 Month **Physician** VIRGIL LEE DAVIS 0905 March /Medical 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WICOMICO PENNINSULA REGIONAL MEDICAL CENTER SALISBURY 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthpiace (Stata or Foreign Country) 1⊠M 2□ F Months Days Hours Yrs. 219-14-3173 APRIL 24,1904 MARYLAND Usuat Residence of Decedent 10e. State 10h. County 10c. City, Town or Location 10d. Inside City Limits YOYes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 WALNUT ST. 21801 U.S.A. Funerai 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Black, White, etc. 11. Maritel Status 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marriad 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TIMBER CUTTER LUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ADA GOLDSBOROUGH PARSONS DAVIS 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) VIOLA CULP - DAUGHTER 1221 JOHNSON RD SALISBURY, MARYLAND 21804 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) WICOMICO MEMORIAL PARK 3-26-99 SALISBURY, MARYLAND 22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. BOUNDS FUNERAL HOME, INC.

23a. Part 1. Entar the disease, or complications that cause of the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. SALISBURY, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Deligdratin Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events rasulting In death) Lest Due to (or as e consequence of) Physician/Medical Dua fo (or as e consequenca of): Part II. Other algnificent conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown by 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was en eutopsy parformad? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner?

1 Yes 2 No Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 🖳 Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (ttem 23a) (Type, Print) 12, Sal sbury and 2 404 ocke 100 31. Date filed (Month, Day, Yea()) 32. Registrar's Signature

State Registrar

MAR 2 3 1999



	1. [Decedent's Name (First,	Middle, Last)		3011			Death	2. Date of I			Vaca	3. Tima of De
ian	M	argaret W.	Ette	ers						March	9 19	-	Year	4:58 p.
ical ner	48	Facility Nama (If not ins	titution, giva	street and number)				4b. City, Town, o	r Location of De		c. County	of Deeth	4.JU.p.
		823 Shelby	Drive						Oxon Hi	11	F	rince	e GEO	RGE"S
		ocial Security Number	6. Se:			last birthday)	If Unde Months	er 1 Year	If Under 24 H Hours Mi	rs. 8. Dete of B	Birth Year)		ice (Stata or Fo
		9-18-7141		M 2DXF 8	31	Yrs.	rescut to the	Days	TIOUIS IVII					rolina
	-	uel Residence of Decedo			100 08	y, Town or Loc	ation							d. inside City L
-	1500	. State 100. C	ourity		100. 01	y, Town of Loc	ation						10	1 ☐ Yes 2)
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Dy r		1 ☐ Never Married 2 [1 ☐ Yas ②☐ If Yes, Give Year or Datas		1	☐ Yes	2 No	Specify:			Specify:		
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Completed		(Specify only	highest grad	e completed)		(Giva k	ind of w	ork done	during most of w	orking	100.1	Nilla of Bu	Siriosaririo	1511 y
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		atricia McF						,		Hill, MI				
	-	. Method of Disposition		,	20b. f	Plece of Dispos		-		Date	-		City or Tow	m, Stete
		1 Burial 2 Crem			3					2/15/00	111:	1 D	NT	0 1
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	21.	No.	2 //	1 1		Ge	orge	P.	Kalas F	uneral H	Home,	P.A.		
_		AN C	Ma	(m) //		61	60 ()xon_	Hill Rd	. Oxon I	Hill,	MD.		
	23	Enter the disease shock, or heart failure	ese, of complete. List only of	na ceus on éach	ine.	h. Do not anta	r tha mo	de of dylr	ng, such es card	ac or respiratory	errest,			Approximete Intarvel Betwee Onsat and Dea
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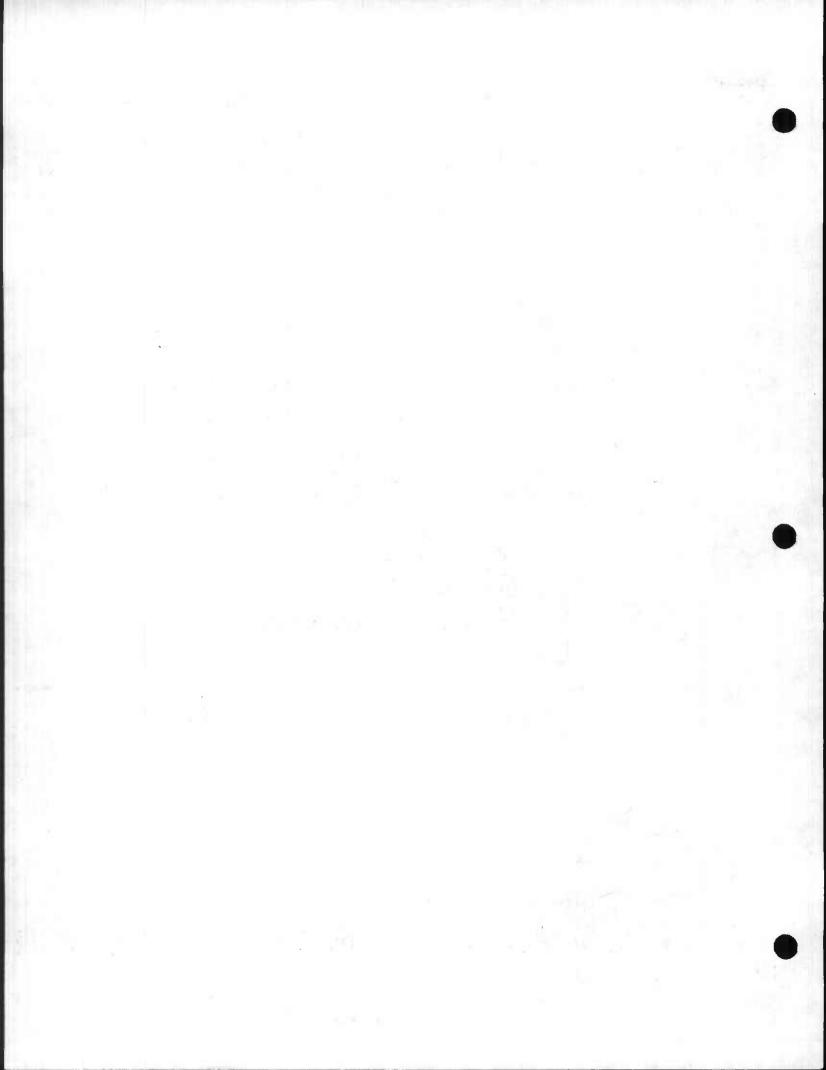
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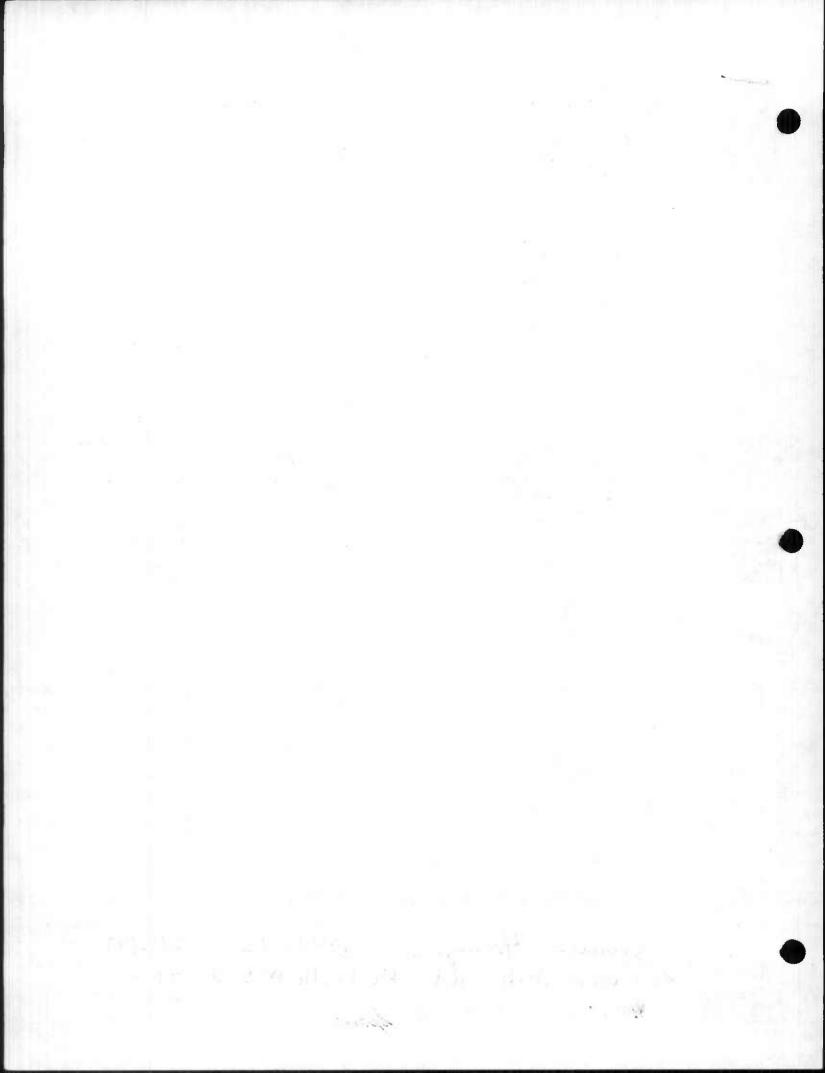
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dale of Death 1. Decedent's Neme (First, Middla, Last) Month Day **Physician** enne 1999 10:30 AM 10, 199° 4c. County of Death /Medical ility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner baltmore Bultimore Mary lanc If Under 24 Hrs. If Under 1 Year iel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 T F 215-64-7188 Yrs. Director August 24,1954 Washington D.C. Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 27343 Burch Manor Circle 20659 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 XNo Specify Specify: 3 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Carpet Installer 9th Self. permit. Pages 1 and 2 should be fried w. Department of Health and Mental Hygien (important) if term 27 is marked other the any Injury or other transmission 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) 86 Kenneth Albert Eberle Doris Edna White 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mike Deaton/Son 24373 Half Pone Point Road, Hollywood, MD 20636 20e. Method of Disposition

1 Duriel 2 Commention 3 Removal from State 20b. Plece of Disposition (Neme of cematery, cremetory or other place) Date 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Metropolitan Crematory 3/14/99 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, P.A. tardiner P.O.Box 270, Leonardtown, MD 20650 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Thue to (or as a consequent Box 68760. holic Physician/Medicai attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? the á 2□ No 3 Probably 4 Unknown signed t Division of Vital Records. 2 24b. Ware autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu page 2 hes 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes No. 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Attanding 5 ☐ Pending i or Attanding after death. Director: After 1 | Yes 2 | No Invastigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral D Hospital edical 29e. Certifier TEL Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end manner steted. \$ 29b. Signatura and little of certilier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 31. Dete liled (Month, Day, Year MAR 1 5 32. Registrar's Signeture Year) State 1999 Registrar



				iviaiyia	_	tificate of		Mental Hy	Reg. No. 9	10063
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Examiner		4a. Facility Neme (If not institution, g						r Location of Deet		
	.	Sunrise Assist 5. Social Sacurity Number 6.			n In at high days	If Under 1 Yeer	Rockvi			gomery
Funeral Director		111-01-4355 Usuei Residence of Decadent	Sex → M 2□F	8 8	s. lest birthday) Yrs.	Months Days			rm ey, <i>Year)</i> L, 1911	9. Birthplece (State or Foreign Country) Pennsylvani
anow data		10e. Stete 10b. County	omery		City, Town or Lo					10d. Inside City Limits XIXYes 2 □ No
a or 28s-f show the notified at Director		10e. Street end Number	omer y		NOCK V I	10f. Zip Code			10g. Citizen of W	
	3	8 Baltimore F	Road			2085	50		US	Α
Examiner must be notified by Funeral Director		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Dece Armed For XXYes If Yes, Give Year or Da	ces? 2 No] 9	42-		Hispenic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, atc.)		a - Amarican Indien, k, White, etc.
Completed		15. Decedent's (Specify only highest g Elementery/Secondary (0-12) 1 2		4or 5+)	16e. Deced (Give life. L		petion during most of we d)	orking	US Pos Service	stal
To Be C	1.	17. Fether's Neme <i>(First, Middle, L</i> as Joseph Finkels	tein		0201	4.6		ame (First, Middle (Unknow		a)
Ene		19e. Informant's Name/Relationship Robert Finkels		n		-		Rural Route Numb		
any injury or other tr	-	20e. Method of Disposition Typeriel 2 Cremetion 3 4 Donetion 5 Other (Spec	☐Ramovel from S	20b.	Plece of Dispo cametery, cren	sition (Nema of natory or other ple	ce)	Dete 3/12/99	20c. Location - LOWER I	City or Town, Stete Moreland, sylvania
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State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificate of	f Death	F	leg. No.	2 1.1	1000
		1. Decedent's Nama (First, Middla, Last)					2. Date of Daa Month			3. Time of Death
	ysician Medical	Agnes C. Fisc	her				March	13, 199	99	12:15 am
25	aminer	4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
8		Catonsville Commo	ns Nursing H	Home		Catonsvil	1e	Balti	imore	
Fun Dire	eral ctor	210-12-0100	7. Aga (In y	rrs. last birthday Yrs.	Months Day		8. Data of Birth (Month, Day Jan. 31	Year) , 1920	9. Birthplac Country Mary 1:	ce (State or Foraign y) and
yland	14	Usual Residence of Decedent 10a. Stata 10b. County	10c.	City, Town or L	ocation				100	d. Inside City Limits
Mer Mer	otor et	Maryland Prince G	eorge's H	yattsvi	11e					1 No 2 No
5 th	ole en	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country	y?
th wi	al C	4203 Kennedy Stre	et		20781		I	J.S.A.		
Maryland 21215-0020 ad 2 should be filed within 72 hours efter death with the Meryland tith end Mentel Hygiene. 77 is marked other than "natural", or Items 23a or 28a-f show	n, the Medical Examiner must be notified Completed by Funeral Director	11. Marital Status 1 ☐ Naver Marriad 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorcad	12. Was Decedent Evar in Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates:	n U,S. 13	. Was Decedent of If Yes, specify Cu 1☐ Yes 2∏ N	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecity Yes or No- Rican, atc.)	Blac	e - Americar ck, White, et Whit	c.
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arylan should be ind Mentel	To	Robert F. Clark				Dorothy	E. Hunt			
Aar 2 sho end is m	Eng.	19a. Informant's Name/Relationship (Ty				et and Number or Ru				
1 end Health em 27	her tr	B. Daniel Fischer				ck Road,				
altimore, mit. Peges 1 er pertment of Hea	or of	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	emoval from Stata	cem etery, cri	position (Nama of ematory or other p		Date	20c. Location -		
Fee Per	lun	4 ☐ Donation 5 ☐ Other (Specify)	M		itan Cre		3/16/99	Alexand	ria, N	Virginia
Baltimore, N permit. Peges 1 end Depertment of Health Important: if Nem 27	any in	21. Signature of Funeral Service Licanse) Gase	1	22. Name and Add Gasch's 4739 Bal	fress of Facility Funeral Ho timore Ave	me, P.A	attsvil	le. MD	20781
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To the Hospital within 24 hours To the Funeral	ompletely filled in by Medical Certifi	29b. Signature and title of cartifie	and manner stated.		29c. 1 ice	ensa number		29d. Date signe	d (Month. D	ay, Year)
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/	51	of chedral C	yerup		Dates	J 7 7		DATE)////
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Registrar

State

31. Date filed (Month, Day, Year)

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Please 1	Гуре or Print in	Black Indeli	ble Ink.	Assure Al	I Copies A	re Legib	ble.
	State of Maryla		ent of He			ene 9 9	10866
1. Decedent's Nama (First, Middla, Last)				2. Data of Death		3. Tima of Death
Michael Philip 4a. Facility Nama (If not institution, giva			4b	. City, Town, or Lo	Month March cation of Death	13 1 4c. County of	999 4:44a.m
Holy Cross Hosp	oital		S	ilver S	nrina	Montg	omerv
5. Social Sacurity Number 6. Sa		Yrs. Mon	noar i Taar	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day,	Yaar)	9. Birthplaca (Stata or Foreign Country)
Usual Rasidance of Dacedant	400	No. Town and a self-			-10010		- ' '
10a. Stata 10b. County	100.0	City, Town or Location					10d. Insida City Limits 1 X Yas 2 □ No
Md Prince Go 10e. Street and Number	eorge's Up	per Marlbo	ro . Zip Coda		10	g. Citizen of W	
107 Joyceton Terr	12. Was Dacedant Evar In	U.S. 13. Was D.	0774 acedant of His	panic Origin? (Sp. Maxican, Puarto	ecify Yas or No-		- Amarican Indian,
1 Navar Married 2 Married 3 Widowed 4 Divorced	1 X Yas 2 No if Yes, Giva Yaar or Datas:		as 2 XNo	Specify:	nican, atc.)	Specify:	R, Whita, atc.
15. Decedant's Edu (Specify only highast grad		16a. Decedant's l	Usual Occupat	on ring most of work	ina 1	6b. Kind of Bus	
Elamantary/Secondary (0-12)	Collaga (1-4or 5+)	Managem		ring most of work		Private	Industry
17. Fathar's Nama (First, Middla, Last)		Tioning 5 in		8. Mothar's Name	a (First, Middla, M		
Henry Joseph Floy(19h Melling Add	Irass /Straat or	Evelyn N	AcIntyre	City or Town	State Zin Code)
Margaret Floyd /W		T	•		oer Marli		
20a. Mathod of Disposition		Place of Disposition	(Nema of				City or Town, Stata
1 ☑ Bunal 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Ma	ryland Vet			3/19		nam, Maryland
21. Signatura of Funaral Service Licens Namau A.	Percentio	J. B.	a and Addrass JENKI Landov	NS FUNER	AL HOME Landove	r, Mary	land 20785
23a. Part1. Entar tha disaata, or compl shock, or heart failure. List only or	lcations that causad the da na causa on aach lina.						Approximata Intarval Batwean Onset and Death
Immediata Causa (Final disaasa or condition rasulting in daath)		FAILL					several most
	10/00-	or as a consaquance		R CH	TR (IN DM	1	severel months
Saquantially list conditions, if any, leading to immediata causa. Enter Undartying Causa (Disaasa or Injury	COA9	(or as a consequence	of): - 1 Y				severel month
that initiated evants rasulting in daeth) Last	Dua to H G P A	or as a consequance		ATWH	ASC US	56	several month
Part II. Other significant conditions con		sulting in the underlying $\{\mathcal{ED}/\mathcal{N}\mathcal{G}\}$	ng causa givan	in Part I.			tribute to the cause of death? 3 Probably 4 Unknown
<i></i>					24a. Was an	autopsy	24b. Wara autopsy findings available prior to
						./	completion of causa of death?
25. Was casa rafarred o medical					1 🗆 Yas		1 Yas 2 No
axaminar?	lospital:	TER/Outpotions of	Othar		Check only ona		- (P-ne/f-)
27. Manner of Death 1 Natural 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury a Work?	t Nursing Ho	ma 5 Rasidar 28d. Dascribe hov		
2 Accidant invastigation 3 Suicida 6 Could not be datamined	28a. Place of Injury - At building, atc. (Spec	homa, farm, street, facility)		s 2 No	28f. Location (Stre City or Town,		r or Rural Routa Number,
29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kn nar: On tha besis of axamin	owledge, daeth occur ation and/or Invastiga	red at tha time tlon, in my opir	, dete end place, nion, daath occurr	and due to the ceu ed at tha tima, dat	usa(s) snd man la and place, al	nar as stated. nd dua to tha causa(s)

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other trsumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral Director

29b. Signatura and title of centiller

30. Name and address

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

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Completed

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Certification:

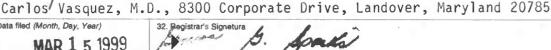
Medical

The law requires that the death certificate be executed cate has been signed by the attending physiclen and page 2 should be detached for use as the buriel-tran After this certificate has director, pletely filled in by the funeral

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: Within 24 hours efter deeth.

State Registrar

31. Data filed (Month, Day, Year) MAR 1 5 1999



ss of person who completed cause of daath (Itam 23e) (Type, Print)

D19693

29c. Licensa number MD Shate

29d., Date signed (Month, Day, Year)

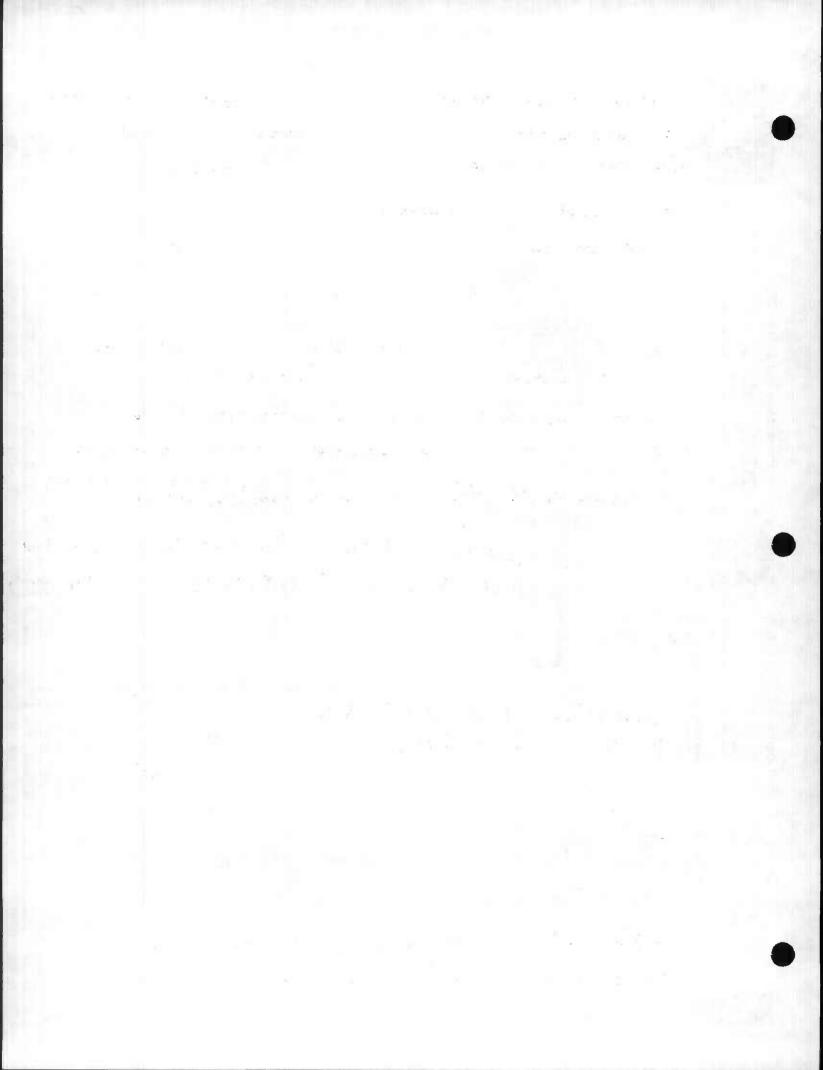
FLOYD, Michael 8.

and the state of the

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Data of Daath 1. Decedant's Name (First, Middle, Last) 3. Tima of Death 1:30pm **Physician** Floyd Calvin Fleming 1999 21 March /Medical 4b. City, Town, or Location of Daath 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Carroll West Mayer Drive Finksburg Hours Min. 8. Date of Birth (Month, Day, Year, Dec 4 1924 If Under 1 Yaar Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days 216-24-6744 1 MM 2□ F 74 Yrs. Md **Director** Usual Basidance of Dacedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Finksburg Md Carroll 1 Yes 2 No Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21048 USA 18 West Mayer Drive Funerai 14. Race - American Indian, Black, Whita, atc. Was Dacedent Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11 Maritai Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiena. Important: If fem 27 is marked other than "natural", or iten any Injury or other treumatic event, the Medical Exercise DOCE. 1 Yas 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 Specifiwhite 1 Yas 2 XNo Specify: p 3 ☐ Widowed 4 ☐ Divorced Yaar or Detes: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Collega (1-4or 5+) Elamantery/Secondary (0-12) supply officer health care 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Josphine Sellman Charles Asbury Fleming 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 18 W. Mayer Dr., Finksburg, MD 21048 Emma May Fleming (spouse) 20b. Place of Disposition (Nama of cemetary, cramatory or othar place)
Lake View Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramovel from Stata 3-25-99 Sykesville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licensaa 22. Nama and Addrass of Facility Haight Funeral Home & Chapel tell 0 P.O. Box 195 Sykesville, MD 21784 23a. Part1. Entar tha disaasa, or complications that eaused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** · VIENTRICULAR Immediata Causa (Finel disaasa or condition rasulting in death) /Medical Examiner Examiner physician end the buriel-transit thet the death certificate be axecuted Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disease or Injury that initieted avents rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of) attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of cause of death? page 2 s certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical axaminar? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Certification: To 1 Yas 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? Injury 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifiar 🔁 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end due to tha causa(s) and mannar as stetad. (Check only one) 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 700A Poole Rd Prof Ctr, WEstminster, MD 21157 Chitrachedu Naganna, M.D. 31. Data filed (Month, Day, Year) 32. Regist/ar's Signature State MAR 2 2 1999 Registrar



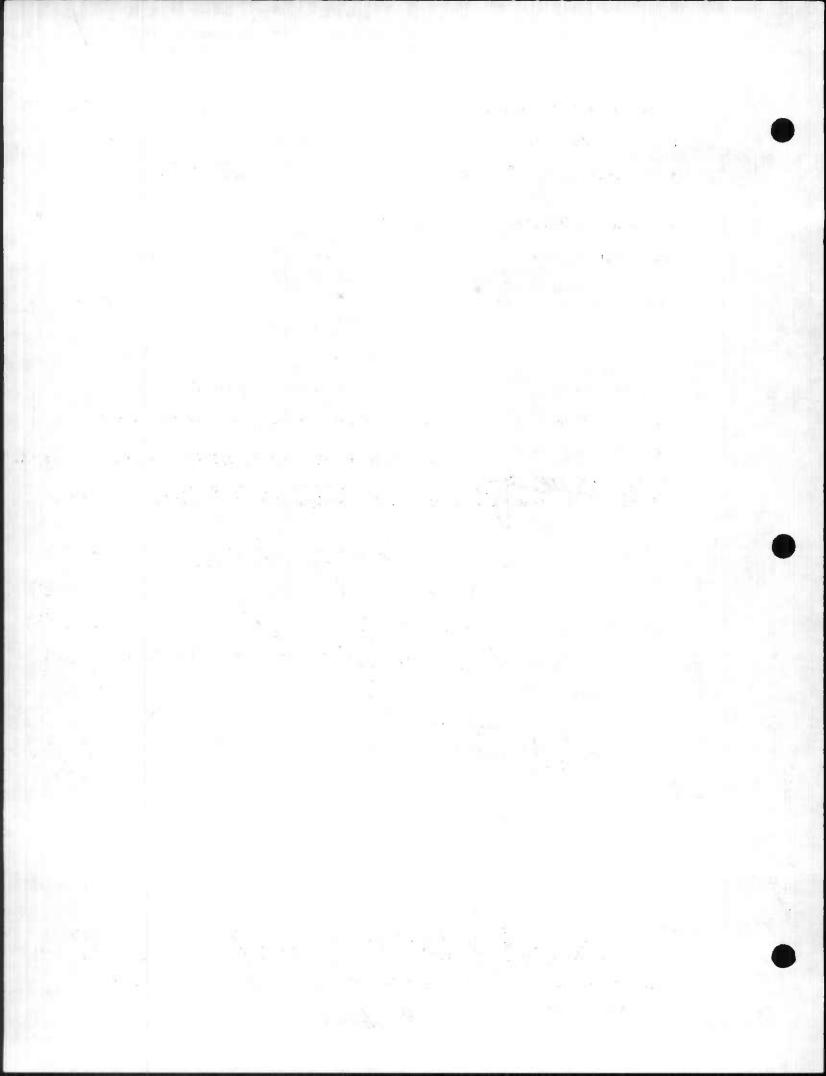
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** 1999 11:50 PM March Catherine Mary Fitzgerald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner St. Mary's St. Mary's Hospital Leonardtown If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** 1 M 2 F Days Yrs. June 28, 87 Colorado 570-09-0967 Director Usual Rasidance of Dacedant the Manyland 10c. City. Town or Location 10a Stata 10h County 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Modical Examiner maint be notified at 1 ☐ Yas 2 ■ No Director St. Mary's Maryland California 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20619 United States 23190 Bent Tree Lane death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ■ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 72 hours after 1 Navar Married 2 Marriad Maryland 21215-0020 1 ☐ Yas 2 ■ No Specify: P 3 Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 2 should be filed within 72 end Mental Hygiena. Is marked other than "ne Flementary/Secondary (0-12) College (1-4or 5+) N/A Housewife 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Josie M. McGrath Lawrence Lyons 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health end Important: If Item 27 is m any Injury or other traum pncs. P.O. Box 144, Leonardtown, Maryland 20650 Edward F. Fitzgerald, Son 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata Arlington National Cemetery 3/29/99 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 24 Signature of Funaral Section 24 22. Nama and Addrass of Facility Michael Brinsfield Funeral Home, P.A. Blankenship, 22955 Hollywood Road, Leonardtown, MD 20650 M00857 K. 23a. Part1. Entar tha disaasa, or complications in a causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximata Interval Between Onsat and Death **Physician** Immediate Causa (Final disaasa or condition resulting In death) da /Medical Examiner Due to (or be a consequence of): Physician/Medical Examiner ettending physician end for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disease or injury that initiated avants rasulting in daath) Last a consequence of) Box 68760, signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. 27 No 3 Probably 4 ☐ Unknown 1 Yes Division of Vital Records, þ The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peed completion of cause of death? certificete has Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: VInpatient 2 ER/Outpatient 3 DOA Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) To 1 Yes 2 No this funeral s after death. 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Deal Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Attending 1□Yes 2□No B ☐ Could not be 3 Cl Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide ò 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manper/stated. (Check only one) within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of death (Item 23a) (Type, Pfint) n . JARBOE M.D. PHILIP J.BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636 JAMES

egistrar's Signature

Registrar

FITZGERALD

CATHERINE



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	Marry V	E-E	- C-1						Month		Day	Yeer	10. (0. 7)
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	land Properties	rince (Georges'		neverly	10f. Zip Co	de			10g.	Citizen of W	Vhet Cou	ntry?
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MARCH 15, 1999 4:10PM GERALDINE MARION GILES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva straat and number) **Examiner** PRINCE GEORGE'S GOLDEN OAKS NURSING & REHABILITATION CTR. LAUREL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours Min 1□ M 21 F 75 Yrs Director 152-22-7378 AUG. 16, 1923 LOVINGSTON, VA Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Vas 2 □ No Director MARYLAND PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 8 238 20781 USA 4923- 56th PLACE Funeral 72 hours efter death нетв ф 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes Give X 14. Race - Amarican Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) Black, White, etc. 1 ☐ Navar Married 2 ☐ Marriad BLACK ò 1 Yas 2 No Maryland 21215-0020 If Yes, Give X Year or Datas: Spacify: g 3 Widowed 4√ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) permit. Pages 1 and 2 should be filed within 1 Department of Heelth and Mental Hygiens Important: If Item 27 Is marked other than "n any Injury or other traumatic avant PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN ASSISTANT 12th 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fether's Name (First, Middla, Last) VIOLET LOUISE BROWN JACOB MOON BROWN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DENISE YOUNG/ DAUGHTER 4923-56th PLACE HYATTSVILLE, MARYLAND 20781 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20a. Method of Disposition 3-20-99 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State POPLAR FLAT BAPTIST CHURCH CEM. LOVINGSTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licental 4308 SUITLAND RD. SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that claused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MINUTES MYOCARDIAL INFARCTION Examiner Due to (or es e consequence of) Examiner physician end the burief-trensit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificete be exec Box 68760 Physician/Medicai Due to (or as a consequence of): esn 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ed by the deteched P.O. signed by t 3 Probably 4 Unknown 1 ☐ Yas 2 € No PERIPHERAL VASCULAR DISEASE g Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed DIABETES completion of cause of death? hes page 2 1 ☐ Yes 2X No 1 ☐ Yes 2 No certificate Mospital or Attending Physician:
 24 hours efter deeth.
 Funeral Director: After this certifical director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Yaar) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rural Routa Numbar, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the To the To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D43260 MARCH 16, 1999 MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

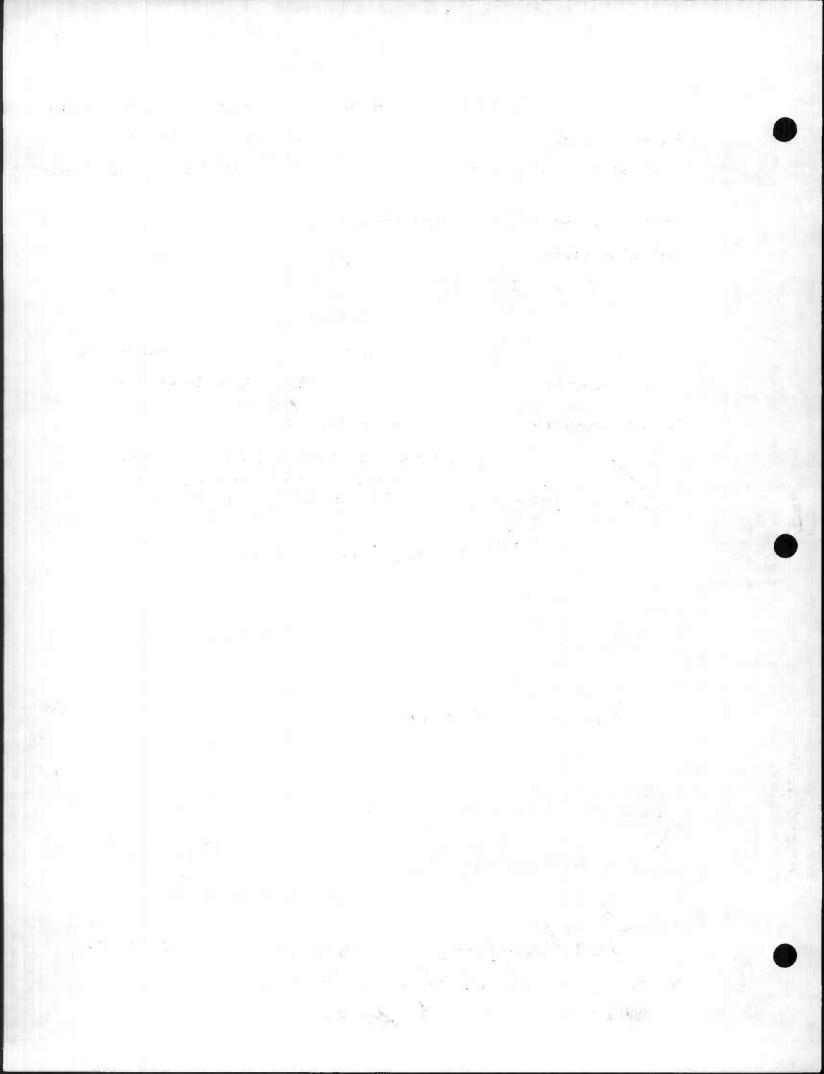


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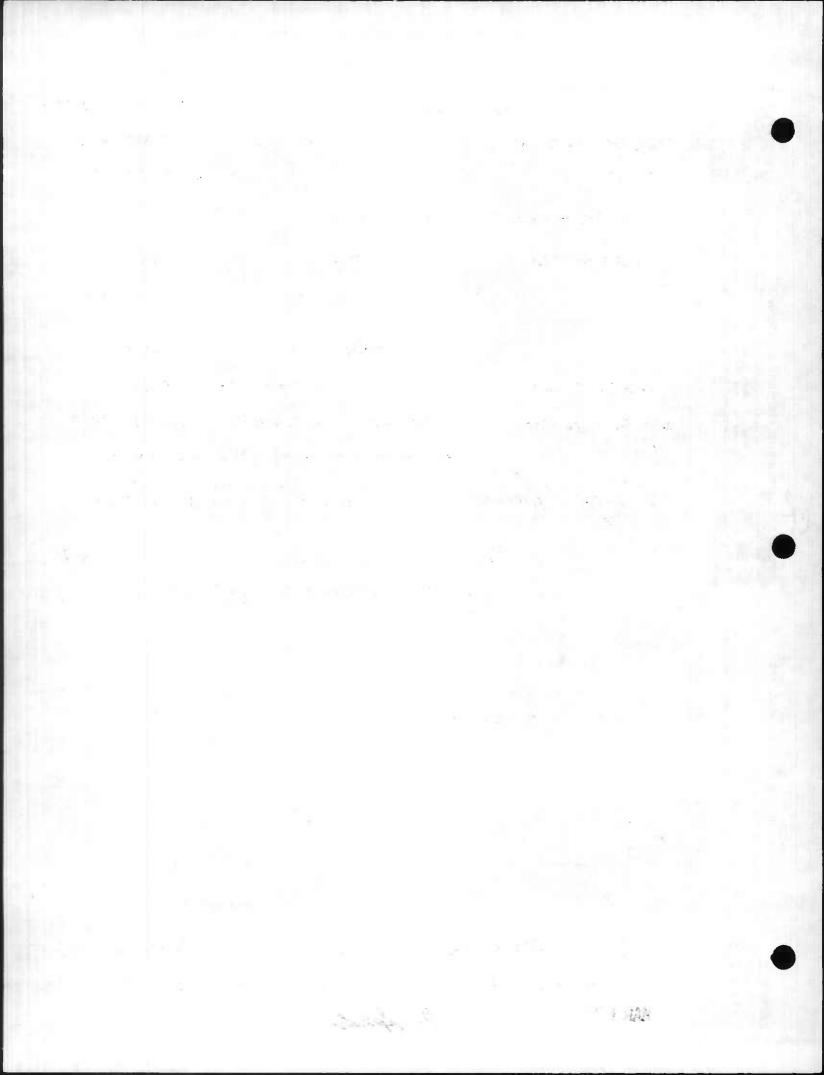
State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day Year JOAN R. M. GOLDSBOROUGH 13,1999 March 1:30 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Prince George's Cheverly Prince George's Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) Months Days 1□ M 2⊠F Hours February 21,1949 Washington, D.C. 577-62-9224 Usual Residence of Decedent 10e. State 10c. City. Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 No Prince William Virginia Woodbridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16777 Brandy Moor Loop 12. Was Decedent Ever in U.S. 22191 U.S.A. 14. Race - American Indian, 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) Self-employed Pet Groomer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Annie Myers Joseph F. Boswell 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Jessica J. Lopez / Daughter 16777 Brandy Moor Loop, Woodbridge, VA 22191 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Spec Ordar Hill Cemetery 3/17/99 Suitland, MD 11. Signature of Funeral Service Lice 22. Name and Address of Facility Cecar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 celar 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): EURAL EFFUSIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last 1 ETASTATIC Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Monknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 July 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Denpatient

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be motified at

Hygiene.

parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Is marked oth any Injury or other traumatic event

the Maryland

death

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records.

Examiner and physician 96 985 ō Š Deen 5 9000

signed the det certificate ž

Physician/Medical à Completed 8 2 Certification:

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State Registrar 27. Manner of Deeth

1 Devaturet

2 Accident 3 Sulcide

4 Homicide

29a. Certifier

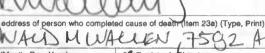
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24 hours a To the To the To the I

29b. Sibrature and title of certifie

5 Pending investigation

6 Could not be determined



28a. Date of Injury (Month, Dey Yeer)

7592 3. Registrer's Signature

ANNAPOLIS ROAD, LANHAM

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

1 🗌 Yes

2 No

28d. Describe how injury occurred

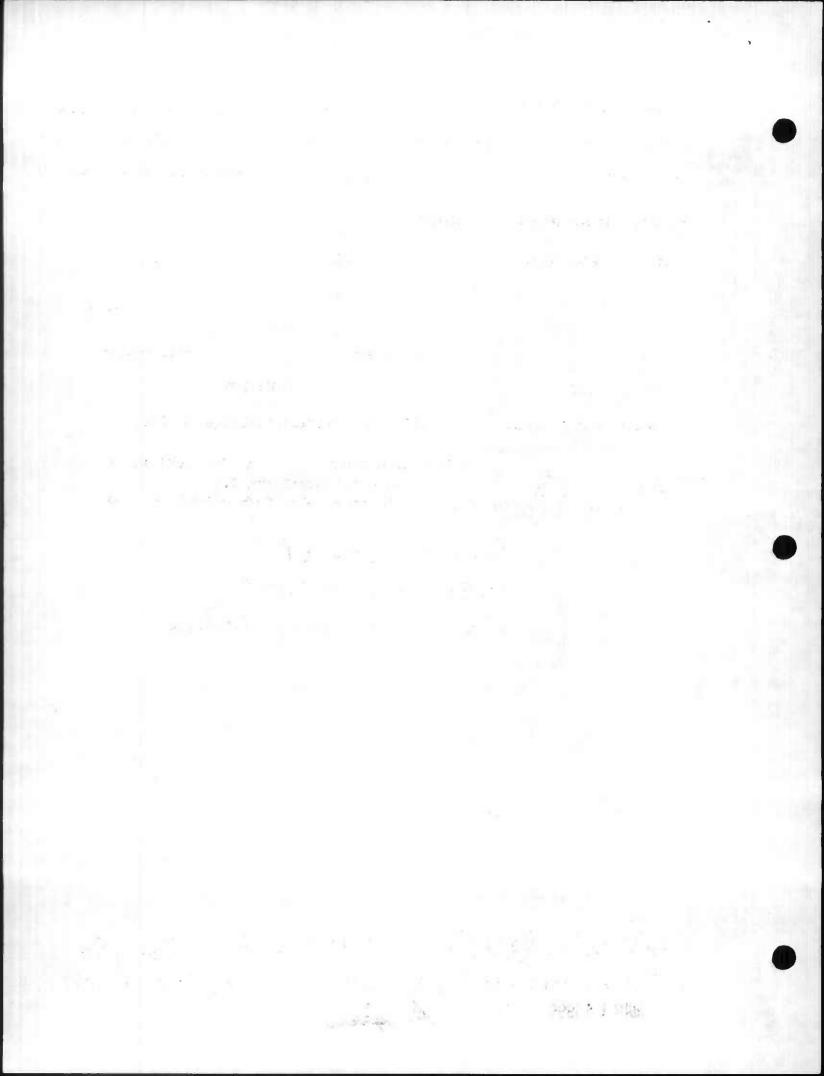
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March 13, 1999 Charles B. Gass 5:30 P.M. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills 2506 Keating St. Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year April 26, (Year) 9. Birthplace (Stata or Foreign Country) Washington, D.C 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 577-26-1990 77 Director Usual Residence of Decedent the Maryland 10c City Town or Location 10d. Inside City Limits 10h County 7 is marked other than "naturel", or items 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 24 No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2506 Keating St. 20748 U.S.A. pormit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "naturel", or itema 23a any injury or other traumatic event, the Man Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 (À/Yes 2 □ No If Yes, Give Year or Dates: 1942–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Fingerprint Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Hyde Robert H. Gass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Mary Alice Gass/Sister 2506 Keating St. Temple Hills, MD 20748 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/16/99 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Koyax 6160 Oxon Hill Rd. oxon Hill, MD 20745 23a. Part1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart full ure. List only one cause on each line. **Physician** PANCREATIC CARCINOMA Immediate Cause (Final //viedical / MONTHS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): SB signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 20 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 □ Ves 2 □ No 1 Yes certificate Hospital or Attending Physician: 25. Wes case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕅 Residenca 6 ☐ Other (Specify) 1 ☐ Yes 20 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral Certification: 27. Manner of Death 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es steted. To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

31. Date filed (Month, Day, Year) MAR 1 5 1999 Registrar

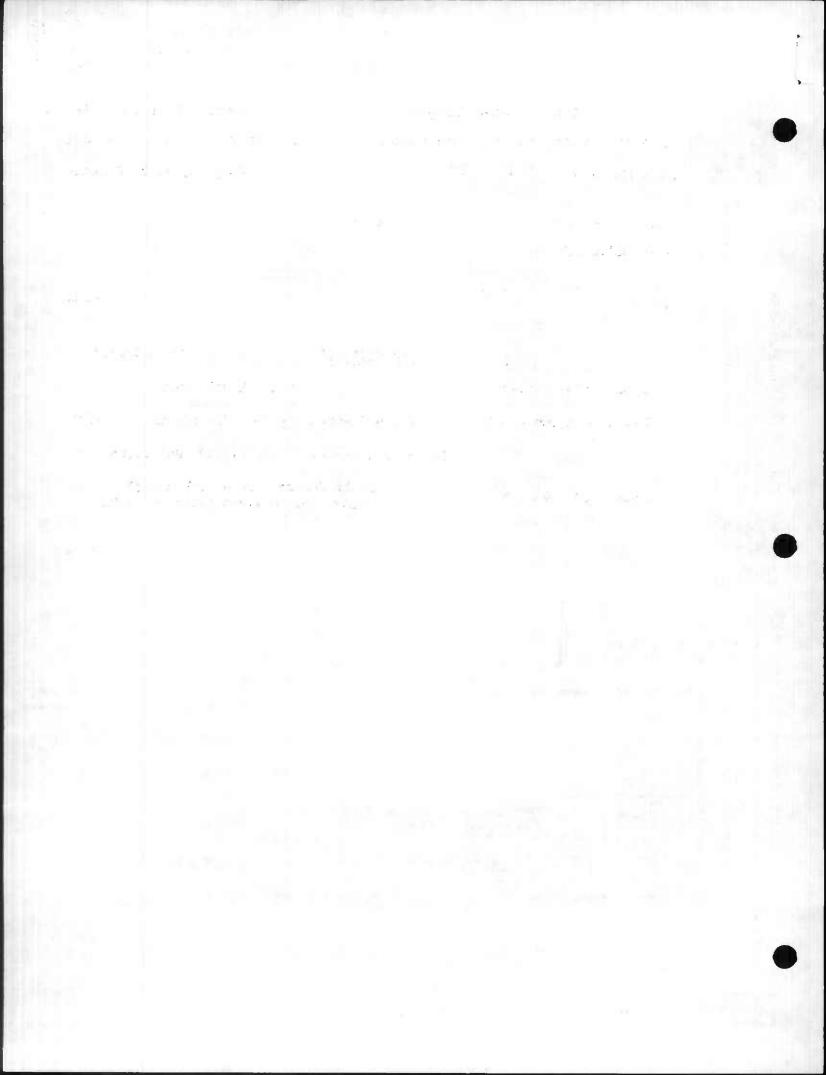
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PITA (1)PTA MD 8926 WOODYARD ROAD #201 CLINTON, MD 20735 32. Registrar's Signature

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Physician Medical Examinar 4a. Facility Name (find institution, give stress and number) 4b. City, Town, condition Obash NATIONAL NAVAL MEDICAL CENTER 5c. Social Security Number 5. Social Security Number 6. Sec. 5. Social Security Number 6. Sec. 5. Social Security Number 6. Sec. 5. Social Security Number 6. Sec. 7. Age (fin yrs. Isad bittinday) 7. Age (fin yrs. Isad bittinday) 7. Age (fin yrs. Isad bittinday) 82 Yrs. 82 Yrs. 82 Yrs. 83 Yrs. 84 Date of Rich 64 Days Huns I Hundar 2 kirs. 85 Date of Rich 65 Date of Part I Country 7. Age (fin yrs. Isad bittinday) 7. Age (fin yrs. Isad bittinday) 82 Yrs. 83 Yrs. 84 Date of Rich 85 Date of	• Ar	ner	nded Per Doc. 3/19			Cert	tificat	te of l	Death			Reg. No.	/ 100	0 1 0
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1) Paresta ND 194374-1 (NY) 3/15/99	Ho Fu Fu	adic	(Check only one) 2 Medical Exa	miner: On the basis and manner	of examina stated.	tion and/or inve	stigation	, in my op	oinion, daa	th occurr	ed at tha time,	data and place,	and due to the	cause(s)
11 1000 27-100 1100	Tom		29b. Signature and title of certifier.				29	c. License	a number			29d. Date signe	d (Month, Day	, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER	(,2)		Vanesta		0			194	374-1	(NY)	3/15/	99	
PAUL D. KANE, LCDR, MC, USN BETHESDA MD 20889-5600	10)				·	n 23a) (Type, P	rint)							NTER

State of Maryland / Department of Health and Mental Hygiene Q

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_		30. Name and address of person who RUSSELL OWEN SCI	IUB, 5999 H	ARPER.	Type, Prin	MRD,	SUITE E21	5, COLUI	MBIAIM.	D 21	044
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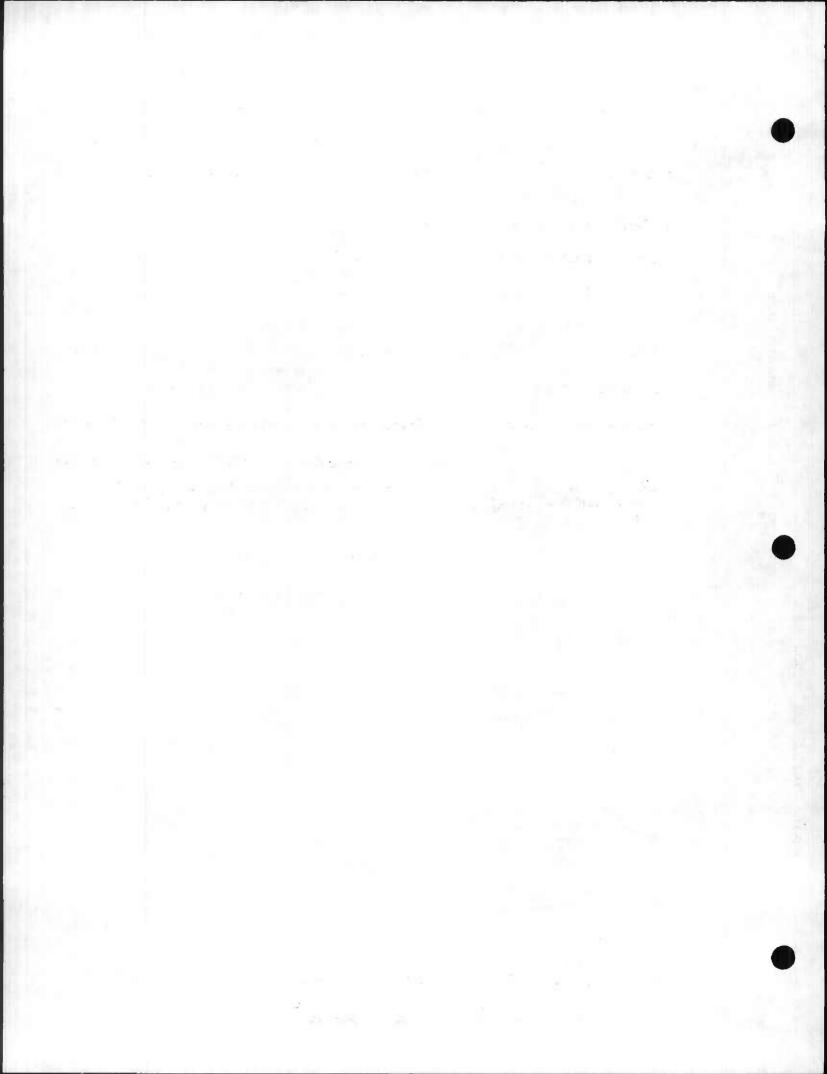
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** March 18, NRAL GATTON THOMAS 1999 2:25a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** LEONARDTOWN HOSPITAL ST. MARNS CO ST. MARYS If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) December 11, 1936 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours Maryland 62 Yrs. 214-34-6944 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Helen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20635 U.S.A. 29855 Pt. Lookout Road Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 💆 No Specify: Specify: il Hygiena. other than "natural", c Year or Dates: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) within Elementary/Secondery (0-12) College (1-4or 5+) 9th Beer Distributor Delivery Person and Mental Hygid traumatic event, 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be permit Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked or say injury or other traumatic every Pearl Lucille Peacock John Thomas Gatton 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 29855 Pt. Lookout Road, Helen, Maryland 20635 Clara Ann Gatton/Spouse Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3/22/99 Charles Memorial Gardens Leonardtown, Maryland 22. Name and Address of Fecility 21. Signature of Funeral Service Lic Mattingley-Gardiner Funeral Home, PA uchase P.O. Box 270, Leonardtown, Maryland 20650 Jardener 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Condice arrest disease or condition resulting In death) Examiner Dua to (or as a consequence of) Examiner attending physician and for use as the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown HEVMATOID ARTIFRITIS Records, 2 The law requires 24b. Were autopsy findings available prior to Completed 24e. Was en autopsy performed? peed VLCERZ completion of cause of death? has page 2 2 PINO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital After this certifical funeral director. Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending death. 1 Yes 2 No 2 ☐ Accident investigation after death Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. edical pletely (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dey, Year) Com 29b. Signature end title of certifier 39605 10mg 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)
Wesley Page, MD SMH Dept. of Emergency Medicine, Leonardtown, MD 20650 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature boards MAR 23 1999 Registrar

DHMH 16 Rev 6/95

THOMAS NEAL GATTON

NAME:



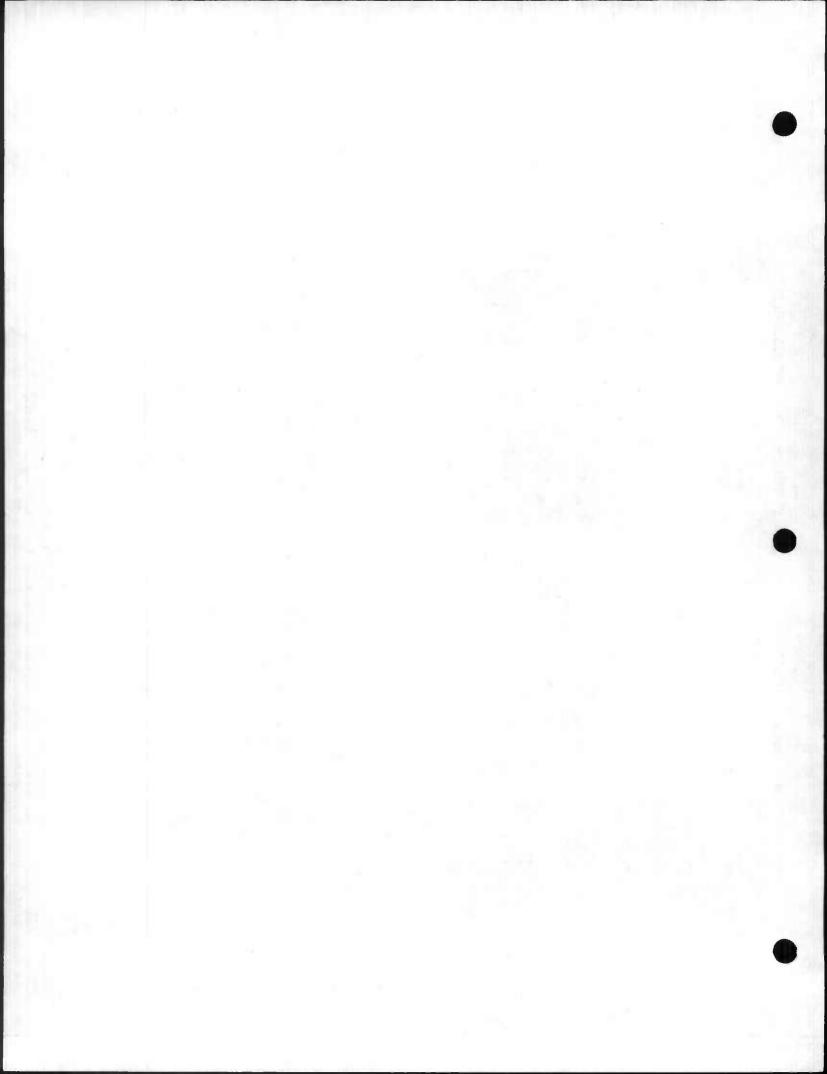
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 March 11, **Physician** 7:50 p.m. Elizabeth Gertrude Glass /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Sept 2, 1906 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral* 1 □ M 210 F Months Days Hours 92 Maryland **Director** 215-44-8820 Usuel Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If flam 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, tra Marial Examinations in notified and any and any injury or other traumatic event, tra Marial Examinations. 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 No Yes 2 No Director Accident MD Garrett 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 101 Town View Drive, Apt 20 21520 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forcas? 14. Raca - American Indian, 11. Marital Status Bleck, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7 th Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be August Charles Georg Catherine Anna Schevel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Glass/son 403 Fairway Dr., Oakland, MD 21550 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cem. Mar. 13, 1999 Accident, MD 21. Signature of Funerel Service Licensee 22. Neme and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 23e. Pert1. Enter the disease or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final atherosclerotic cardiovascular disease 10 min disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physician end requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): ettending ph ned by the e Part II. Other significent conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cerebrocascular disease with right cerebrovascular XXNo 3 Probably 4 Unknown Records, à sign 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? Completed been accident and left hemiplegia completion of ceuse of deeth? The law I page 2 s chronic renal failure 1 ☐ Yes X☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician; 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 ☐ Yes 2 ☒ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) Aftar 5 Pending 1 XNeturel after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the ceuse(s) end menner es steted. 29a. Certifier To the Hosp within 24 hou To the Fune completaly fil edical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dav. Year) 29b. Signeture end fitte of certified 29c. License number D25759 March 11, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 6 Walter K. Naumann, M.D., PO Nox 247, Accident MD 21520 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Physician Imogene March 21, 1999 Gordy 12:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico # Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sax 7. Age (In yrs. lest birthday) **Funeral** Days Hours 1□ M 2♥ F Yrs. 221-09-4881 79 5-17-1919 Director Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Rems 23s or 28s-f show must be notified at Yes 2 No Directo Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 E. Chestnut St. 21875 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after Yes 2X No 1K Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 4 Teacher Junior High School permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If them 27 is manked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George William Gordy Daisy Wright Gordy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd 4 Box 968 Laurel, De. 19956 Geraldine Dickerson, Cousin 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 ☑Donalion 5 ☐ Other (Specify) 3-21-99 Baltimore, Md. 21201 Anatomy Board of Md. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Short Funeral Home, Inc. Dolly Short-Hannigan 700 West St. Laurel, De. 19956 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximala tnterval Between Onset and Death **Physician** Androwsulm Diserse /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760 edical that initiated events resulting in death) Last Due to (or as a consequence of): Physician/M P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 6 Weiner (5 1 Yes The lew requires that Records, p 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? Completed peed hes 22 No 1 Yes 2 No 1 Yes certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 DNatural To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funere Medicai Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of Signature 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1104 Healthway Dr., Salisbury, MD Michael R. Atkins, M.D. 21804 31. Date filed (Month, Day, Year) MAR 2 4 1999 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day March 14,1999 **Physician** Yaar MYRTIE E. HUDGINS 4:31AM /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not Institution, give street end number) 4c. County of Death **Examiner** DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 7. Aga (In yrs. lest birthday) | ff Undar 1 Yaar | ff Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplaca (Stete or Foreign 1 M 2 F Yrs. 577-26-1922 1922 MARYLAND Usual Rasidanca of Dacedeni 10a Stata 10h County 10c. City, Town or Location 10d. insida City Limits 1 Yes 2 No Director MARYLAND PRINCE GEORGE'S COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8623 CUNNINGHAM DRIVE 20740 UNITED STATES Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Bleck, White, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: þ Specify: 3 X Widowad 4 □ Divorced WHITE 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) SCHOOL BUS AIDE 12+ BOARD OF EDUCATION 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) LOUIS THOMPSON LENA GROVES 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RICHARD H. HUDGINS, SON 8623 CUNNINGHAM DRIVE, COLLEGE PARK, MD 20740 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 3/18/99 BRENTWOOD, MARYLAND 21. Signature Funeral Service Licensee 22. Nama and Addrass of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE YEARS tmmediata Cause (Final disaase or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequanca of) Part II. Other algnificant conditions contributing to death but not rasulting in the undarlying causa givan in Part i. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disease PV 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Thyroidesm 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raferrad to medical Be 26. Placa of Death (Check only one) Hospital: 1 Yas 2 No 1 ☐ inpatiant 2 XER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Medical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be 28e. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian 29b. Signatura and title of certifian 29d. Data signed (Month, Dey, Year)

State Registrar

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examiner mant to notified at

permit. Peges 1 end 2 should be filed within 7; Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other traumatic event, the Media 2006.

Physician

/Medical

Examiner

physicien and s the burial-transit

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To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certific completaly filled in by the funeral director,

signed b

Box 68760,

P.O. F

Records,

Division of Vital

31. Data filed (Month, Dey, Year)

32. Registrar's Signatura

pleted cause of death (Itam 23a) (Type, Print)

VORE, MA 4203 QUEENSBUAGRE HYGTTSUITE MD 20781

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

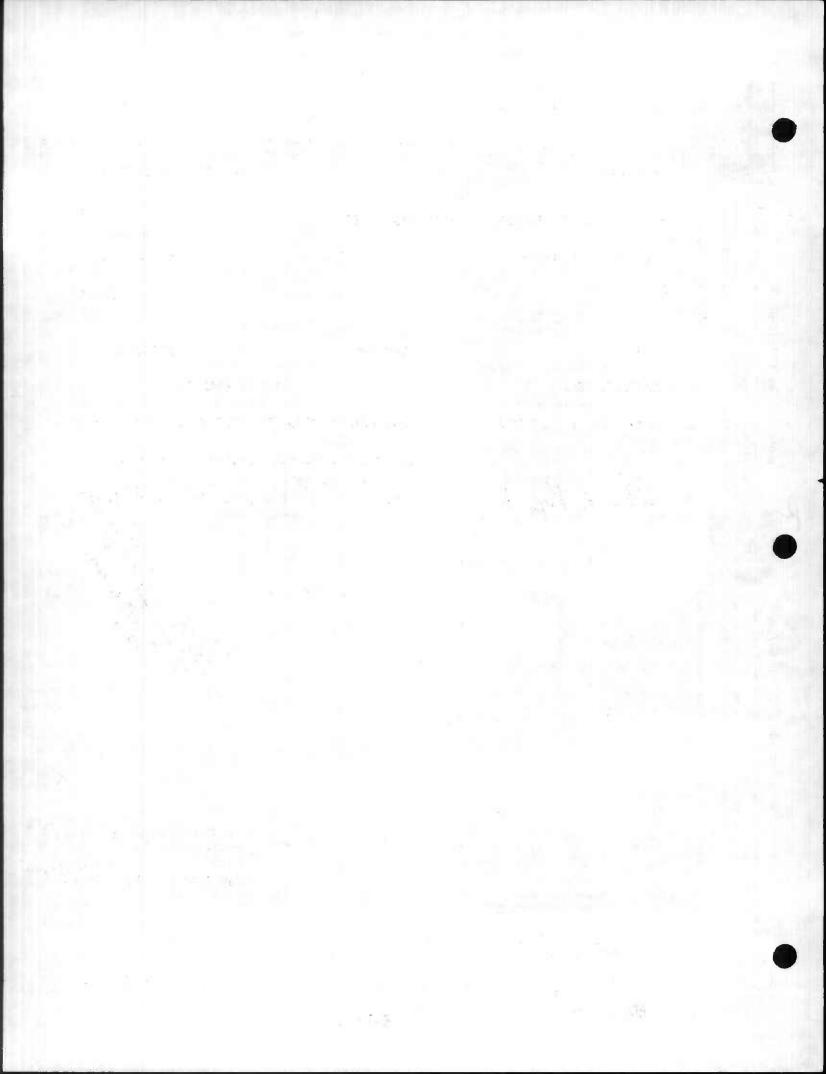
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1213-0020	hin 72 hours effer death with the Maryland B. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by	1 ☐ Never Merried 2 ☐ Married **Widowed 4 ☐ Divorced	1 ☐ Yes 2120 If Yes, Give Year or Dates:	XDXNo 1 ☐ Yes 2 🔀 No Specify:						Whi			
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	Peges 1 end ment of Healti ant: If Itam 27 ury or other I		1 ☐ Burial 2 ☐XCremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci			-	remato:	'	3-18 Arlington,			Va.		
	permit. Peges 1 and 2 should be Department of Health and Manta Important: If flam 27 is marked any injury or other traumatic avoice.		At Constitute and Confine Lineary											
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2	Attending Physician: In daeth. Sector: After this certific by the funeral director,	Certification:	2 ☐ Accident Investigetion				M 1	Yes 2 □ No						
DISINIO	tar d Iract Iract	Ē	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home (Specify)	e, ferm, stre	et, fectory, office		28f. Location (S City or Town	treet end Numb n, Stete)	per or Rure	Route Number,		
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	To the Hospital or Attending Physicien: The within 24 hours eiter deeth. To the Funeral Director: After this certificate completely filled in by the funeral director, per	edicai	29e. Certifier 1 A Certifying Pl (Check only 2 Medical Example)	nysicien: To the best of miner: On the besis of end manner sta	exeminetion	dge, death end/or Inv	occurred et the ti estigation, in my o	me, date end plece opinion, death occ	e, end due to the o urred et the time, d	euse(s) end me late and place,	enner es ste end due to	eted. the ceuse(s)		
	Nithir No th	×	29b. Signatere end title of certifier				29c. Licens	se number	2	9d. Date signe	d (Month, L	Dey, Year)		
			250. Signature of the interior											
(5)		30. Name end eddress of person who completed ceuse of deeth (Item-236) (Type, Print)											
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** 545 PM March Howell 1999 Horacio /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Prince HOS Pital Cente Georges Krince Georges Center Cheverh If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) if Undar 1 Yaar 9. Birthplace (State of Foraign 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Davs 152-74-1704 Yrs. Director 18 MARCH 1,1981 VIRGÍNIA Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at XIX Yas 2 No Director PRINCE GEORGES FORT WASHINGTON the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pages 1 end 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiena. Important: If item 27 is merked other than "naturel; or items 23a any Injury or other traumetic event, the Medical Examinal must once. 9006 ROLLINGWOOD DR. 20744 UNITED STATES Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: BLACK g 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT EDUCATION 18 Mother's Name (First Middle Meiden Surname) 17. Father's Neme (First, Middle, Last) HORACIO HOWELL THELMA BRANTLEY 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THELMA HOWELL / MOTHER 9006 ROLLINGWOOD DR. FORT WASHINGTON ,MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cramation 3 □ Removal from Stata RESURRECTION CEMETERY 3-19-99 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOME 21. Signature of Puneral Servica Licensee 5538 MARLBORO PIKE, FORESTVILLE MD 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) head losed Examiner Due to (or es a consequence of): Examiner ubarachnond requires that the death certificeta be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician er s the buriel-t Division of Vital Records, P.O. Box 68760, tracture Physician/Medical Dua to (or as a consequence of) 10) 40) attending I Sublixation signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown fractures ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy parformed? Completed aw I certificate has b 1 Yes No 1 Yes 2 No or Attanding Physician: funeral director, 25. Wes cese referred to medical examinar? Be 26. Place of Deeth (Check only one) examinar? Yes 2□ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To N Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of Injury (Month, Day Year) 284 Describe how injury occurred PRIVER OF AUTO VS FIXED OBJECT COLLISION 27. Manner of Death 28b. Time of 28c. Injury et Work? Injury 1 Naturel 5 Pending 1380 death. 1 Yes 2 No Investigation March 11 1999 Motor vehicle acciden 2 Accident ofter deatl 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) FORT WASHINGTON, MD 4 Homicide STONESBORD DR. AT PENNS BURDD DR 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 M 51006 March 13 1999 30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print) J.D. Alleyne MD 20785 Itospital Cheserly 3001 31. Date filed (Month, Day, Year)
MAR 1 7 1999 82. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



				State of M	Maryland /		ment of H ficate of L	lealth and M Death		ene	2 1	0063	
	Physici /Medi		1. Decedent's Name (First, Middle, L Andrew H.						2. Dete of Deeth Month MACCH	Dey	Yeer 999	3. Time of Deeth 1:45 pm	
	Examir		4e. Fecility Neme (If not institution, g	All the second second second second	er)		4	b. City, Town, or Lo Lanham	ocation of Deeth	4c. County	of Deeth	orge's	
	Funeral Director			_	Age (In yrs. lest b		Under 1 Year onths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, May 26,		9. Birthple	ece <i>(Stete or Foreign</i> Virginia	
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020	or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1	s? A No	If Ye	s, specify Cube	spenic Origin? (Spen, Mexicen, Puerto Specify:	Rican, etc.) Black, White,				
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,00	icate be executed physician and s the buriel-transit	al Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury the United events)										
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5	the death	Physiclan/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribu										
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5	delan: The	Be Co	25. Was cese referred to medical exeminer?					26. Place of Death	1 ☐ Yes		1 🗆	Yes 2□ No	
5	this aldi	tion: To	1 Yes 2 HO 27. Menner of Death 1 Whaturel 5 Pending 2 Accident investigetic	Hospitel: 1 Inpa 28a. Dete of In (Month, D	jury 28b.	Time of Injury	DOA Othe	4 LI Nursing Ho	me 5 Residen 28d. Describe how				
	To the Hospital or Attending is within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	Certification:	3 Suicide 6 Could not idetermined	be 28e. Plece of I	njury - At home, f etc. (Specify)				28f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,	
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	(0)		30. Name and address of person who was a second of the sec	7209A	HANG	(Type, Print	PARK	CWAY C	, 2554	BELT	m!	020779	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 4c. County of Death 7:55 a.m Darnley mosley has Facility Name (If not institution, give street and number) Darnley Howard mar /Medical 4b. City, Town, or Location of Death Examiner Takoma Park If Under 24 Hrs. 8. Data of Birth Min. (Month, Dey, Year) Washington Adventist

5. Social Security Number 6. Sex 7. t Hospital
7. Age (In yrd. lest birthday) Montgomery

9. Birthplace (State or Foreign
Country) If Under 1 Year 6. Sex 1 M 2 □ F **Funeral** Days Months 578 22 0977 Yrs. Jan. 28 1925 Brooklyn, NY Director Usual Residence of Decedent with the Merylenc 10e State 10c. City, Town or Location 10h County 10d. Insida City Limits Yes 2□No Washington, Director 10g. Citizen of What Country? 10e. Street and Number d 2 should be filed within 72 hours after deeth with he not Mental hygiene.
7 is marked other than "natural", or items 23a or treumstic event, the Menical Exeminer manther. 20012 USA N.W. 5+. 1400 Iris Funeral 12. Wes Decedant Evar In U.S. Armed Forces? 1 A Yes 2 □ No Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2X No Baltimore, Maryland 21215-0020 Specify: Specify: Afro. American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 8 U.S. Postal Service College (1-4or 5+) 5+ 4RS Elementary/Secondary (0-12) Engineer 1246 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 end 2 should be lent of Health end Mental Howard E. Mosley Darnley E. Hilda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health e Itoward Unportant of Healt Important: If New 27 any Injury or other tre Same as above Natalie 20a. Method of Disposition
1 Buriel 2 □ Cremation 3 □ Ramoval from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State wash. DC. Creek Cem. 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Facility

John T. Rhines 21. Signature of Funaral Service Licensee 23a Parti. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate Physician /Medical Immediate Causa (Final tailuve DIVATORU disease or condition resulting in deeth) Examiner Examiner ances monoru The law requires that the deeth certificete be executed physicien and the buriel-transit Sequantially list conditions, if eny, laading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequençe at): Division of Vital Records, P.O. Box 68760, Diration Physician/Medical Due to (of as a consequence of). 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Onknown à 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy Completed Mpillitus Diabetes is certificate hes director, pege 2 1 TYes 2 No 1 Yas 2D No or Attending Physicien: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: Injury 1 Maturel 5 Pending death. 1 ☐ Yes 2 No Invastigation ofter death Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end manner stated. 29a, Certifier Medical To the To the To the I 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie 29c. Licansa number dress of person who completed cause of death (Item 23a) (Type, Print)

Frozier M.D

32 Registrar's Signatura

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Id (Month, Dey, Year)
MAR 1 6 1999

11120 New Hampshire Avetyor Silver Spring Md 20904

State Registrar 31. Determed

A WASHING begrippen in other process years in a second Company of the William Company of the Company of th

State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 12, 1999 Patrick Henry Hoppel March 12:56 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1⊠ M 2□ F Hours Yrs. 72 March 15, 1926 Pennsylvania 218-20-1160 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 U.S.A. 14 Greendale Place 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White Yeer or Dates: 1944-46 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Model Maker U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Marie F. Nolan Henry A. Hoppel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Dennese Hoppel - Wife 14 Greendale Place, Greenbelt, Maryland 20770 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/99 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21 Signative of Funerally 4739 Baltimore Avenue, Hyattsville, MD 20781 shock, or hear favore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) unone Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Due to (or es e consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 2 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated. 29a. Certifie (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

P.O. Box 68760. Division of Vital Records, Physician: Attending

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Hygiene. Dither than "naturel", or fleme 23a or 28e-f show ent, the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0020

Hospital 24 hours edical To the Hosp within 24 hor To the Fune completaly fi State

Bertram Weisbaum, MAR 1 5 1999

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)



Registrar

State of Maryland / Department of Health and Mental Hygiene

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Physician / Medical	1. Decedent's Name (First, Middle, Last) ETHEL LEAN HOLMES-WARD									2. Date of De Month	eath Day	Yaar	3. Time of Death
/Medical		LEAN								MARCI	H 11, 1	999	0415 AM
Examiner		(If not Institution, gh DLID BRANCH		nber)				CLINI		ocation of Deat		ty of Death NCE G	EORGES
uneral irector	5. Social Security 250-62-		Sex 1 □ M 2 🂢 F	7. Age (In yrs. I	last birthday) Yrs.	If Undar Months	1 Yaar Days	if Under Hours	Min.	8. Data of Bi	irth ay, Year)	9. Birth	place (State or Foreign
Ctor	Usual Residence							1		Mar.1	8,1938		Carolina
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De notified Director	10e. Street and N		Georges	Da	ndove	10f. Zip	Code				10g. Citizen o	What Cou	ntry?
ai Di	9041 Co	ntinental	Place			20	785				U.S.A.	Α.	
by Funerai		rried 2 Married 4 □ Divorced	12. Was Dece Armed For 1 Yas If Yes, Give Year or Da	2∏ No		Was Deced if Yes, spec 1 ☐ Yas 2		lispanic Or an, Mexica Specify		pecify Yes or No- o Rican, etc.) 14. Race - Amarican Black, White, etc			etc.
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To Be Co		n e (First, Middle, Last pkin, Sr.	•		Accountant 18. Mother's Neme (First, Middle, Maiden Surname) Gladys Mills								
-		Name/Relationship		a		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. 9041 Continental Pl, Landover, Md. 2078!							
	20a. Method of Di	Lee Ward	Husband	20b. Pl	lace of Dispo	osition (Nam	ne of		1	Date 20c. Location - City or Town, State			
Department of Haalth and Mantal Hygiana. Important: If item 27 is marked other than "naturel", or items 23a or 23a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 🖾 Buriai 2	1⊠Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1⊠ Buriai 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 1999 Brentwood,											
	21. Signature of F	Funeral Service Lice	nsee		2	2. Name an	d Addre	ss of Facil	ihr		cins Fu	nera1	Home
а	Scha 4 Sunting) 7474 Landover Rd, Landover Md. 2078												
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by Physician/Medical	disease or condit resulting in death Sequantially list of it any, leading to cause. Enter Uncause, (Disease of that initiated even resulting in death	conditions, immediate derlying or Injury its) Lest	b	Due to (or	r as a conse	quence of):	ause gir	ven in Part	1.	1 = 24a. We	Yes 2 1 10	3 Pro	obably 4 ☐ Unknown
Physician/Medical Examiner	disease or condit resulting in death Sequantially list of it any, leading to cause. Enter Uncause, (Disease of that initiated even resulting in death	conditions, immediate derlying or Injury its	b	Due to (or	r as a conse	quence of):	ause gi	ven in Part	i.	24a. We	Yes 2 No	3 Pro	Vere autopsy findings vailabla prior to ompletion of cause
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To Be Completed by Physician/Medical Examiner	disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death Part II. Other eign 25. Was case referexaminar. 1 🖺 Yes ? 2 27. Menner of Death	econditions, immediate derlying or injury its inificant conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the condition o	b	Due to (or Due to (or Due to (or ath but not result injury, by Year) of Injury - At horg, etg. (Specify	r as a consector as a	quence of): quence of): underlying continued and all DC of 2 in M 2 reet, factory	OA Ott	26. Placeher: 4 □ N	te of Deat	24a. We perform the (Check only) ome 5 Res 28d. Describe	Yes 2 No one) Sidence 6 BC how injury occ	24b. V a c c c c c c c c c c c c c c c c c c	Vere autopsy findings validable prior to ompletion of cause in death? EYas 2 No No Roadway No Life Durant Pour Para Roufe Number.
To Be Completed by Physician/Medical Examiner	disease or condit resulting in death Sequantially list of any, leading to cause. Enter Uncause, Chisease of that initiated even resulting in death Part II. Other eignth of the examinar? 1 1 2 Yes 2 2 27. Manner of Dei 1 Natural 2 2 Accident 3 Suicide	erred to medical No ath 5 Pending investigations of determined	b	Due to (or Due to (or Due to (or Due to (or ath but not result if injury in, Day Year) Gof injury - At hong, etc. (Specif) best of my know know know know know know know know	r as a consect r as a	quence of): quence of): underlying continued in the second of the seco	OA Ott	26. Place her: 4 \(\to \) No at rk? Yes 2 \(\to \)	te of Deat	24a. We perform 5 Res 28d. Describe City or 7.	s an autopsy formed? Yes 2 No one) sidence 6 PC how injury occ (Street and Numown, Stete) BRANCE e cause(s) end	24b. V 24b. V 24b. V 1 24b. V	Vere autopsy findings valiable prior to ompletion of cause of death? EYas 2 No No Roadway No No Roadway No No No No No No No No No No No No No N
al director, page 2 should be detached for use as the burial-transit To Be Completed by Physician/Medical Examiner	disease or condit resulting in death Sequantially list of it any, leading to cause. Enter Uncause, Chisease othat initiated even resulting in death Part II. Other algn 25. Was case referexaminar? 1 X Yes 2 Z 27. Manner of Dei 1 Natural 2 Accident 3 Suicide 4 Homicide	erred to medical No ath 5 Pending investigations of determined	b	Due to (or Due to (or Due to (or Due to (or ath but not rest of injury - At horing, etc. (Specify best of my knowsis of axaminet	r as a consect r as a	quence of): quence of): underlying continued in the second of the seco	OA Ott	26. Place her: 4 \(\to \) No at rk? Yes 2 \(\to \)	te of Deat	24a. We perform 5 Res 28d. Describe City or 7.	s an autopsy formed? Yes 2 No one) sidence 6 PC how injury occ (Street and Numown, Stete) BRANCE e cause(s) end	24b. V 24b. V 24b. V 1 24b. V	Vere autopsy findings valiable prior to ompletion of cause of death? EYas 2 No No Roadway No No Roadway No No No No No No No No No No No No No N

62. Registrar's Signature

State Registrar

MAR 1 5 1999

AND THE PARTY BOUNDED

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

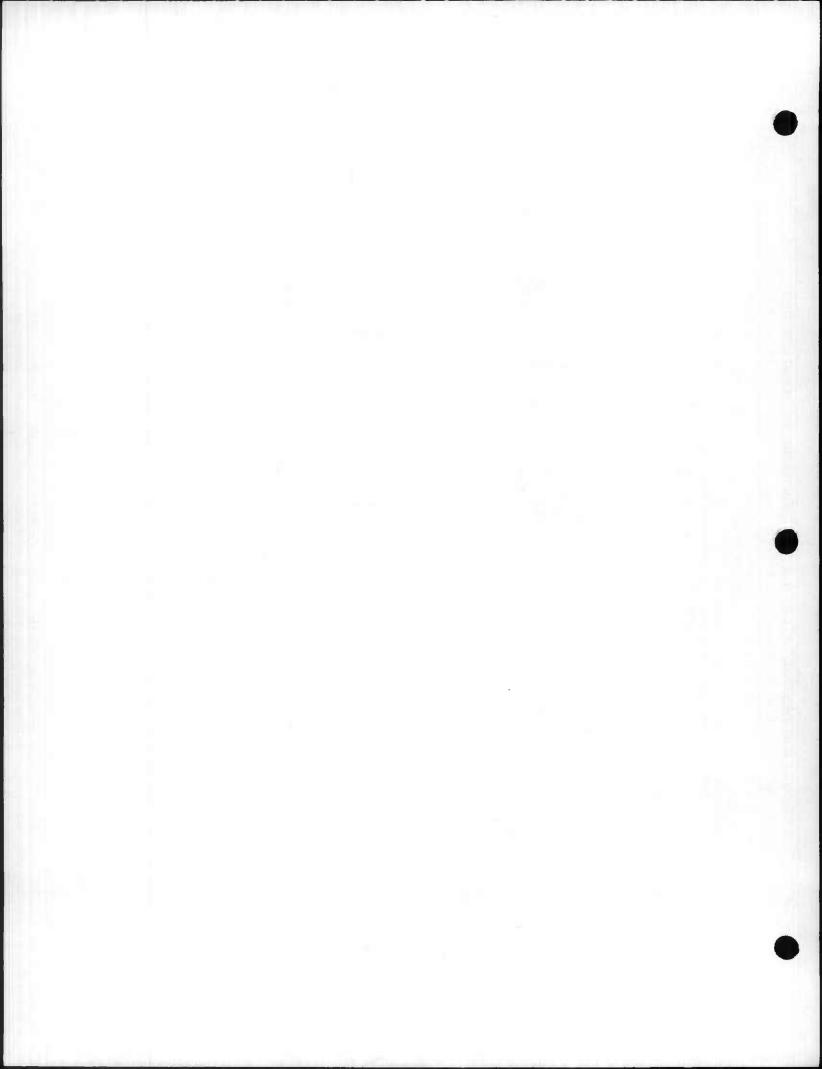
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

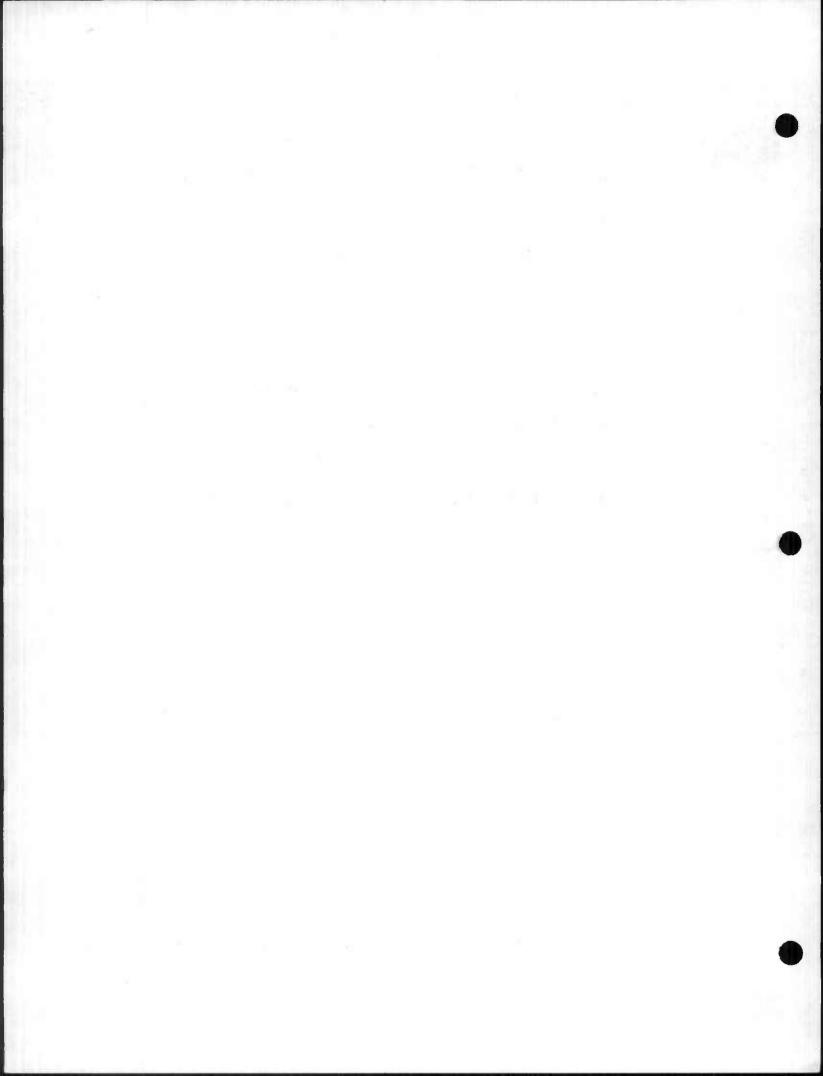
REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO.						
1. DECEDENT'S NAME (First, Middle, Las					2. DATE OF DEATH	AY YEA	3. TIME OF DEATH				
Evelyn Paulin					March 12	199					
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGI	(In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	C	NRTHPLACE (State or Foreign country)				
214-10-2127		O) THS.			Feb. 18,		Maryland				
9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY					
9 S. Second St	<u> </u>			Woodsbo	ro	Fre	ederick				
10a. STATE 10b. COUR	YTY	10c. CIT	r, TOWN OR LOCA	TION		10d					
Maryland	Frederick		W	oodsboro			LIMITS?				
10e. STREET AND NUMBER			10	H. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
9 S. Second S	t.		mil.	21	.798	U	.S.A.				
11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc.				
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR			S 2 X NO Specif			Specify:				
							White				
16. DECEDENT'S E (Specify only highest gra		16a. DECEDENT'S	USUAL OCCUPAT work done during m he retired.)	ION lost of working	16b. KIND OF BU	SINESS/INDUST	RY				
Elamentary/Secondary (0-12)	College (1-4 or 5+)	owner/or			beaut	y shop					
17. FATHER'S NAME (First, Middle, Last)		1 3		16 MOTHED'S NO	ME (First, Middle, Maiden						
William Henry A	brecht				Wa Shuff	SATTERITY)					
19a. INFORMANT'S NAME (Type/Print)		19b, MAILING									
John G. Huffman, Jr./ son 14 S. Main St. Woodsboro, MD 21798											
John G. Huffman, Jr./ son 14 S. Main St. Woodsboro, MD 21/98 20a. METHOD OF DISPOSITION (Name of commettery, cremetory or 20c. LOCATION — City or Town,											
1 Surial 2 Cremation 3 Red Donation 5 Other (Specify)	emoval from State	Mt. Hope	Cemeter	Cemetery 3/15/99 Woodsboro, MD							
21. SHONATURE/OF FUNERAL BERVICE LICENSEE 2 22. NAME AND ADDRESS OF FACILITY Hartzler Funeral											
Valha.	1) 4/2.7	and a			Hartzle	er Fune	ral Home				
23. PART 1. Enter the diseases, of	O' LAMO	4		S. Main			MD 21798				
IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CLIBN VASCV (ar a Ca. Vent M DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
that initiated events resulting in death) LAST											
	d										
PART II. Other eignificent condit	ione contributing to deet	but not resulting	In the underlyl	ng cauea given in	Part I. 24a, WAS APPERFO	RMED?	24b, WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO				
25. WAS CASE REFERRED TO MEDICAL			26.	PLACE OF DEATH (C	heck only one)						
EXAMINER?	HOSPITAL:	utpatient 3 DOA	OTHER:	me 8 Mesidence	8 Other (Specify)						
27. MANNER OF DEATH	28a. DATE OF INJUF (Month, Day, Yea	Y 28b. TIM	E OF 28c. II	NJURY AT YORK?	28d. DESCRIBE NOW	INJURY OCCUR	ED				
Netural 8 Pending		, m.		YES 2 NO							
2 Accident Investigation 3 Suicide 8 Could not determined	28e. PLACE OF INJU- building, etc. (S	IRY — Al home, farm, pecify)	street, factory, of	lice	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
(Check only	IYSICIAN: To the best of my kn		23111222123	-3			ause(a) and manner as state				
29b. SIGNATURE AND TITLE OF CERTI	FIER _ /			29c. LICENSE NU	IMBER	29d. DATE SI	GNED (Month, Day, Year)				
(XIII	alle mi			D310	58	▶ Mar	rch 12, 1999				
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	, Print)								
Gene F. Ashe, 1	1D, 10200 Con	permine F	Road, PC	Box 6, 1	Woodsboro.	MD 217	798				
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S		Sour								
MAR 1 8 19	99 Deper	J.	Ann V	/							



					State of M	arylan		artment o <i>tificate</i>			Mental Hy	/giene		0888
	Physic /Medi		1. Decedent's Nama		estut	ler					2. Data of D Month 3	eath Day	Year 99	3. Tima of Death
	Examii Funeral Director		4a. Facility Name (If 5. Social Sacurity Nu 370 48 45 Usual Rasidance of	mber 6. Sa		a (In yrs.	last birthday) Yrs.	If Under 1 Months D	<	If Undar 24 H Hours Mi	rs. 8. Deta of B	Car	roll	lace (Stete or Foreign try)
	ylend wor		10a. Stata	10b. County		10c. Cit	y, Town or Lo	cation					10	0d. Inside City Limits
	Man a-f sh	ctor	Md.	Howard		N	<i>l</i> oodbin	e						1 ☐ Yes 2/□/No
	or 28	Dire	10e. Street and Num					10f. Zip Co	oda			10g. Citizan of V	Whet Coun	try?
	ath w	ral		A.E.Mulli					179			U.S.A.		
020	urs efter de al', or Itema Examinat	by Funeral Director	11. Maritei Status 1 ☐ Nevar Marrie 3 ☒ Widowed		12. Was Dacedant Armed Forces? 1 Tas 2 18 If Yas, Give Year or Datas:		If	Vas Decedan f Yes, specify I □ Yas 2🎗	Cuban	panic Origin? , Maxican, Pus Specify:	(Specify Yas or No- arto Rican, atc.) 14. Race - Americ Black, Whita, Specify: Whi			atc.
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours effer death with the Marylend Depertment of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "hatural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Exercises prust be notified at 2006.	Completed	(Spacifi Elementary/Secon	15. Decedant's Edu y only highast grad dary (0-12)	cation la <i>complatad)</i> College (1-4or s	5+)	(Give I	lant's Usual O kind of work o OO NOT usa r	occupet fona du atired)	iion <i>iring</i> most of w	vorking	16b. Kind of Businass/Industry		
	hould be filed with! Mentel Hygiene. marked other than matic event, the M	Be Co	17. Father's Nema (/	First, Middla, Last)					T	18. Mothar's N	ama (First, Middle			
Maryland	should be nd Mente marked	ToB	Joseph D	. Powell						Matt:	ie M. Bro	ooks		
Jar	2 sho		19a. Informent's Nar								Rural Routa Numi		Steta, Zip	Coda)
	1 end Heelth em 27 xther tr		Dean Gaud 20a. Mathod of Dispo	•	Daughter)	20h P	P.O.			odbine,	Md. 21	797 20c. Location -	City or To	we Ptate
nor	Pages nent of I int: If its		1 Burial 2 □	Cramation 3 P		0	ema <i>tary, cram</i> estlawn	natory or otha	r place,		3/22/99	Marriot		
Baltimore,	permit. Pag Depertment Important: It any Injury o		21. Signetura of Fun			t	22.	. Nama and A	Addrass	of Facility Sykes	sville, M	/d. 2178	4	
	-	Н	23a. Part 1. Enter the	a disaase, or compl	ications that dausag	tha daath					ome & Cha		. Box	Approximeta
	Physician /Medical Examiner		Immediata Causa (F disaase or condition resulting In daath)	inal	na causa on aach li	ein			2 M	enti	a			Intarval Batween Onset end Death
Box 68760,	death certificete be executed et et et ending physician end d for use es the buriel-transit	Physician/Medical Examiner	Sequentially list con- if any, laading to imr- causa. Entar Under Causa (Disaasa or li that initiated events rasulting In daath) Lo		o	Due to (o	to (or as a consequence of): to (or es e consequence of): to (or as a consequence of):							
	the ett	sici	Part II. Othar algnific	ant conditiona cor	ntributing to death b	ut not rasi	ulting In tha un	nderlying caus	a givar	n in Part I.	23b. Dld	tobacco usa co	ntribute to	the cause of death?
P.0	that the de ed by the deteched		HYP	ERTE	NSIO	N					1□	Yes 2 No	3 Prob	pably 4 ☐ Unknown
Records,	requires seen sign	Completed by										s an autopsy ormed?	ava	ara autopsy findings aliabla prior to appletion of cause daath?
	The ate h	Con									112	Yas 2□No	1 🗆	Yas 2X No
of Vital	Physician: this certific ral director,	Be	25. Wes cese referre axaminar?		lospital:				Othar		eeth (Check only			
	ding Phy h. After this funeral o	ation: To	27. Manner of Death 1) Netural 2 Accident	5 Panding Invastigation	1 ☐ Inpatie 28a. Dete of Inju (Month, Da)	ry	ER/Outpatient 28b. Tima of Injury		Injury : Work?	4 Ed Nursing	Homa 5 Res	Idence 6 □Oth how Injury occur)
Division	5 # 5 5	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be datarmined	28e. Place of Injubulding, etc	ury - At ho	ma, farm, stre	aat, factory, of	ffice		28f. Location City or To	(Straat and Numb wn, State)	er or Rura	Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir. completely filled in	edical	29e. Certifiar (Check only one)	Certifying Phys	alclan: To the best on nar: On the basis of end mannar sta	axaminat	wledga, daath ion and/or inv	occurred at trestigation, in	he time my opi	, dete and pla nion, daath oc	ce, and dua to the curred at tha tima	causa(s) and ma , data and place,	annar es st and dua to	eted. tha cause(s)
	withir To th	Me	29b. Signatura and ti	tle of certifiar	1 2	11		29c. LI	cansa	number		29d. Data signe	d (Month, L	Day, Year)
			J. f. m	restine	Who	jht		1) 9	52	140	3/19	619	4
_			30. Name and eddre	ss of person who co INE WR	ompleted cause of d	aath (Item	23a) (Type, F FR R.T	Print) DGE,	5	YKES	VILLE		217	84
	Sta Registr		31. Deta filed (Month	Day, Year)	32. Registr	ar's Signa		. de						

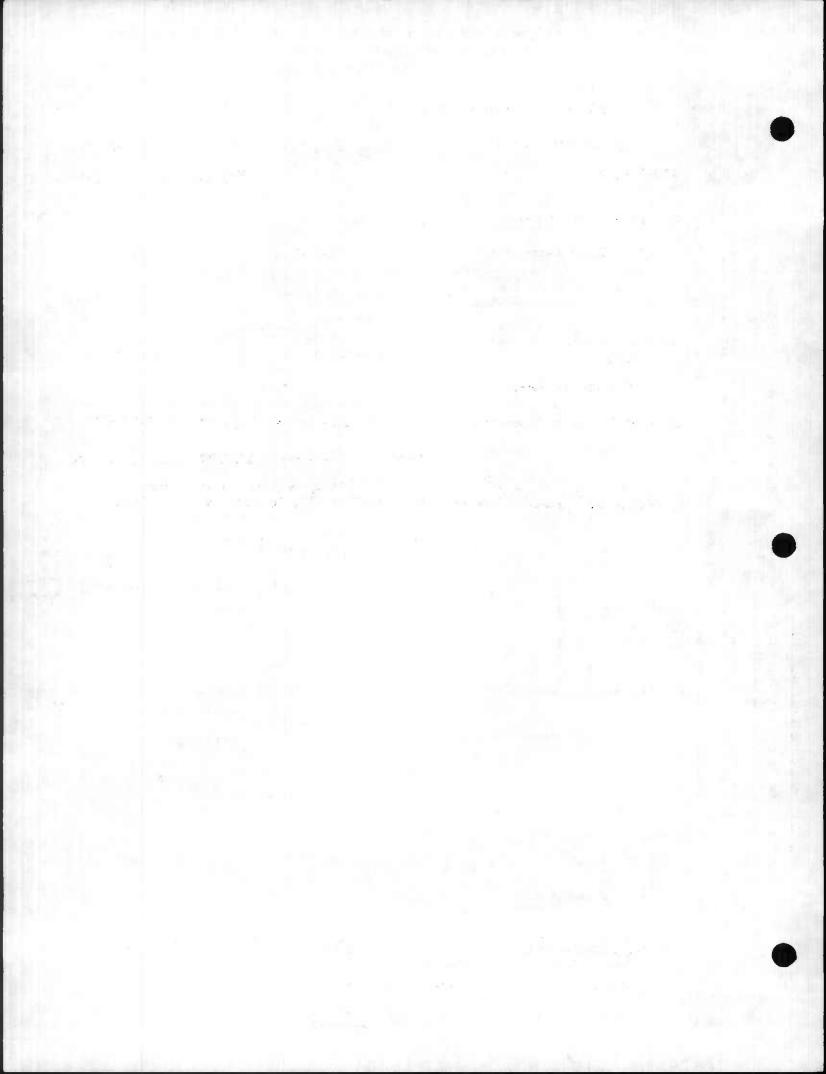
DHMH 16 Rev 6/95

Hoffstutler



DHMH 16 Rev 6/95

MARJORIE VIRGINIA HALL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day March 16, 1999 6:10 AM Teresa Evangeline Heard 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 9, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 F Yrs. Maryland 72 218-24-7046 Usual Residence of Decedant 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20636 42384 St. John's Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12th Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) William Robert Abell Roseanna Pope 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42384 St. John's Road, Hollywood, Maryland 20636 Joseph P. Heard / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 3/19/99 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the deat to not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and/Death Immediate Cause (Final disease or condition resulting in death) PULSIONAM INSUFFICIANCY SEVERE KIABHO SCLUISKS Due to (or as a consequence of)

Physician /Medical Examiner

physician and s the buriel-transit

attending pl

Examiner

Physician/Medical

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Completed

Be

Certification: To

edical

Physician

/Medical

Examiner

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Funeral

à

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

	ontributing to death but not resulting in the underlying cause given fear feelur	in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow				
0		24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No				
25. Was case reterred to medical		26. Place of Death (Check only one)				
exa <i>m</i> iner? 1 ☐ Yes 2 ☒ No	Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 🛱 Natural 2 Accident 5 Pending investigation	28a. Date of injury (Month, Day Year) 28b. Time of injury 28c. tnjury a Work?	at 28d. Describe how injury occurred				
3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ysician: To the best of my knowledge, death occurred at the time ntner: On the basis of examination end/or investigation, in my opin and manner stated.	, date end pleca, end due to the ceuse(s) and manner es steted. nion, deeth occurred at the time, date end place, and due to the ceuse(s)				

29c. License number

D19052

California, Maryland 20619

29d. Date signed (Month, Day, Year)

March 17, 1999

or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the should be detached is certificata has director, paga 2: funerai To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: At completely filled in by the fu

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

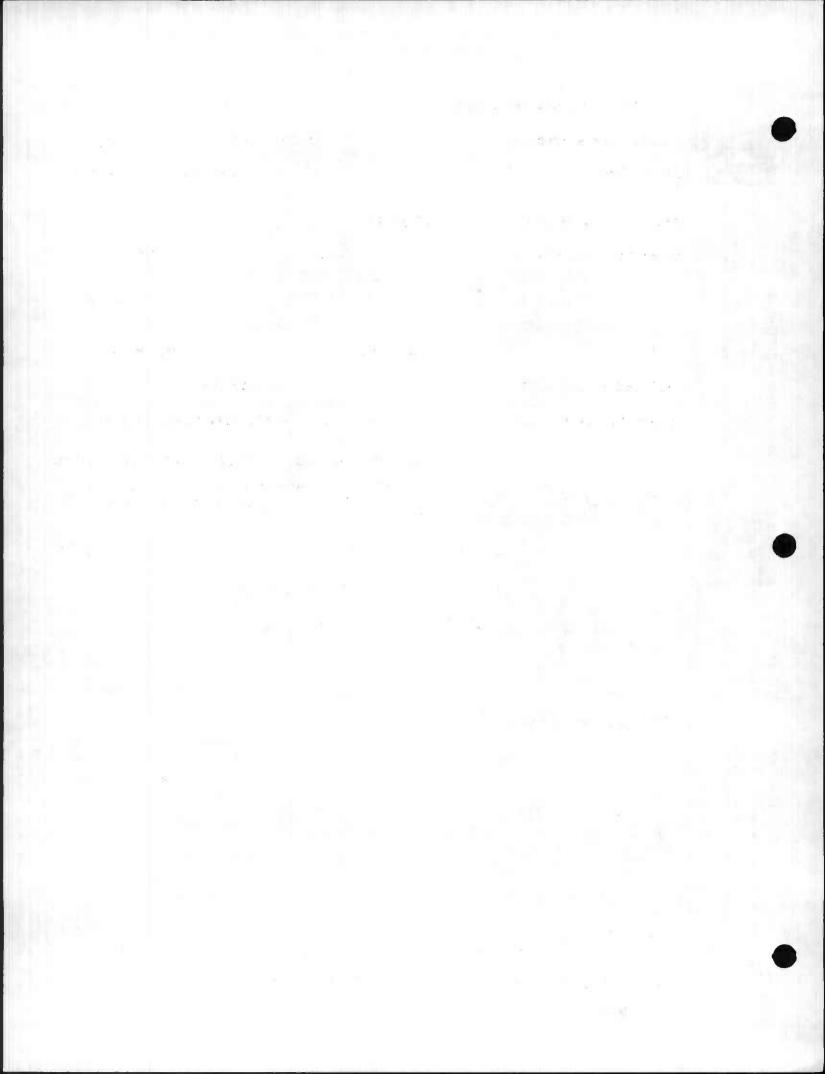
Dr. John L. Bennett

Dunit M/D

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

MAR 1 8 1999

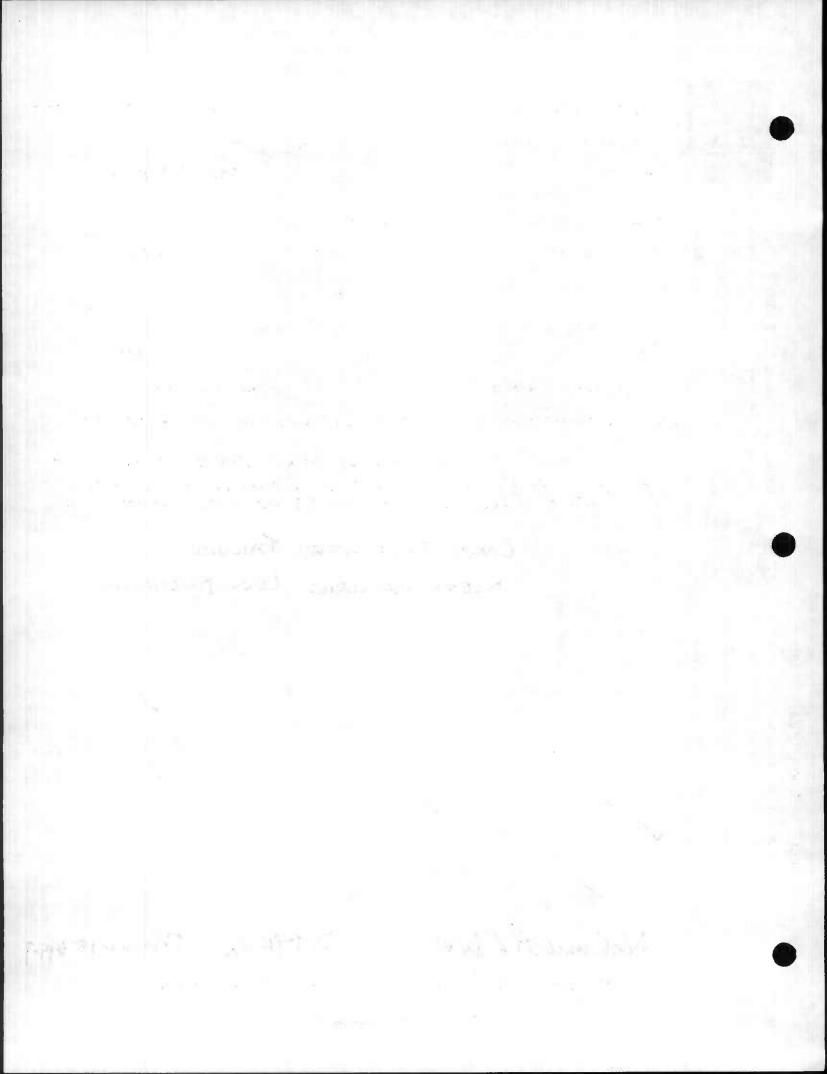


State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Re	g. No.	2	10021			
	1. Decedent's Name (First, Middle,	Last)					2. Date of Deeth		VIII	3. Time of Deeth			
Physician	Myliayh Jana	e Herbert					Month March 1	7, 199	Year 9	4:47p.m.			
/Medical Examiner	4a Facility Name (If not institution,				4b. City, To		ation of Death	4c. County	of Death				
Examiner	St. Mary's H				Loons	nd to.	m	C+	Manu				
			(In yrs. last birthday	If Under 1 Year	Leona		8. Date of Birth	St.	Mary	S lace (Stete or Foreig			
Funeral		1 M 2 DF	/ Yrs.	Months Days	Hours	Min.	(Month, Day,	Year)	Cour	ntry)			
Director	216-43-4058		4				January 5	1995	Mar	yland			
pu *	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					1	0d. Inside City Limits			
anyla anyla										1 ☐ Yes 2 🕅 N			
o M	Maryland St. Mar	ry's	Mechanic	sville						18100 24011			
th th	10e. Street and Number			10f. Zip Code			10	og. Citizen of \	What Cour	ntry?			
h will	40785 King Dri	ve		2065	9			U.S.	Α.				
filed within 72 hours after death with the Manyland Hygiena. wher than "natural", or items 23s or 28s-f show ant, the Mailes Excepted for the contract of Completed by Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U,S. 13.	Was Decedent of H	lispanic Orl	gin? (Spec	cify Yes or No-			an Indian,			
T Francisco	1 Never Merried 2 Married	Armed Forces?		_			ncan, etc.)		k, White,	etc.			
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2∭ No	Specify:			Specify	" B1	ack			
ied within 72 hor tygiena. The than natura tt, the wedied Completed	15. Decedent's	Education	16a. Dece	edent's Usuel Occup	oation		1	16b. Kind of Business/Industry					
in 7.	(Specify only highest		life.	e kind of work done DO NOT use retire	<i>during</i> mos d)	t of workin	19						
with ther	Elementary/Secondary (0-12)	College (1-4or 5+		N/A				N	/A				
Hygiel C	17. Father's Name (First, Middle, La	(st)		117/1	18. Mothe	er's Name	ame (First, Middle, Maiden Surname)						
ntal H od oth													
J Ment J				N 4 1					le Chase				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiena. Department of Health and Mertal Hygiena. Important: If than 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, its Maillest English martines and injury or other treumatic event, its Maillest English martines and injury or other treumatic event, its Maillest English martines and injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event, its Maillest English and Injury or other treumatic event ev	19e. Informant's Name/Reletionship			ling Address (Street									
and n 27 ner tu	Tywanda M. Chase	e/Mother	20b. Placa of Disp	85 King D	rive,	Mech							
tan Har	20a. Method of Disposition	Dete 2	20c. Location -	City or To	own, State								
Page ont: If	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Queen of	Peace Ce	meter	v 13	/20/99	Heler	. Ma	ryland			
ortal	21. Signature of Funeral Service Lic	ensee. /	2	2 Name end Addre	ess of Fecili	hv							
Deparation of the parameter of the param	Mattingley-Gardiner Funeral Home, P.A.												
	Michael K. Lardyner P.O. Box 270, Leonardtown, Maryland 20650												
	23a. Part 1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deel												
Physician	shock or heart failure. List only one cause on each line.												
/Medical	Immediate Ceuse (Final disease or condition	LARI	NORES	PIROTO	27	FAI	LURE						
Examiner	Immediate Ceuse (Final disease or condition resulting in death) LARDIO RESPIROTORY FAILURE Due to (or as a consequence of): METACHROMATIC LEUKODYSTROPHY												
e e	METACHEOMATIC LEUKODYSTROPHY												
aath certificata be axecuted attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions.	V	ue to (or as e conse				/						
Ex rial X	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying								1				
Sicilia De	thet initiated events	c	ue to (or as a conse	guence of):					-				
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nding use a	100	d											
that the daath certed by the attending datached for use Y Physiclan/N							1						
the ched	Part II. Other significant conditions	s contributing to death but	not resulting in the	underlying ceuse gr	ven in Part	1.				o the cause of deati			
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S E E													
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D 28 W								,	of	mpletion of ceuse death?			
page comp							1 □ Ye	s 2 No	, , ,	☐Yes 2☐No			
s cartificate has director, page 2						-10				65 2010			
cartific rector	25. Was case referred to medical examiner?	Hospital:	_/		her-		(Check only on						
00	1 Yes 2 No	1 Linpatien		SIIL SLI DON	4 LIN		ne 5 Reside			fy)			
o fa fa	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo			28d. Describe ho	w injury occur	160				
Arrending tr death. ector: After by the fune iffication	2 Accident investigat			M 1	Yes 2□	No							
ard by	3 ☐ Suicide 6 ☐ Could no determine		y - At home, ferm, s (Specify)	treet, fectory, office		2	28f. Location (St. City or Town		ber or Run	al Route Number,			
Se aft	40		(-,,,										
hour ners	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, dea	th occurred at the ti	me, date en	nd place, a	nd due to the ce	euse(s) and m	enner as s	stated.			
to the Hospital or Amending Pro the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical Ex	aminer: On the basis of e and menner stete	examination and/or to	nvestigation, in my	opinion, dea	ath occurre	ed et the time, da	ate and place,	and due t	o the cause(s)			
To the Hospital or within 24 hours afte To the Funeral Direct completely filled in Medical Cert	29b. Signature and title of cartifier	12 01		29c. Licens	se number		2:	9d. Date signe	d (Month,	Day, Year)			
- s - ō	Molana	1 th / New	S	T	11-	PEG	79	Accepted all					
	Mohand & Lyar D 17582 March 18.199												
2	30. Name and address of person wh												
		er, M.D., F	.A.A.P.	Holly	wood,	Mary	/land 20	0636					
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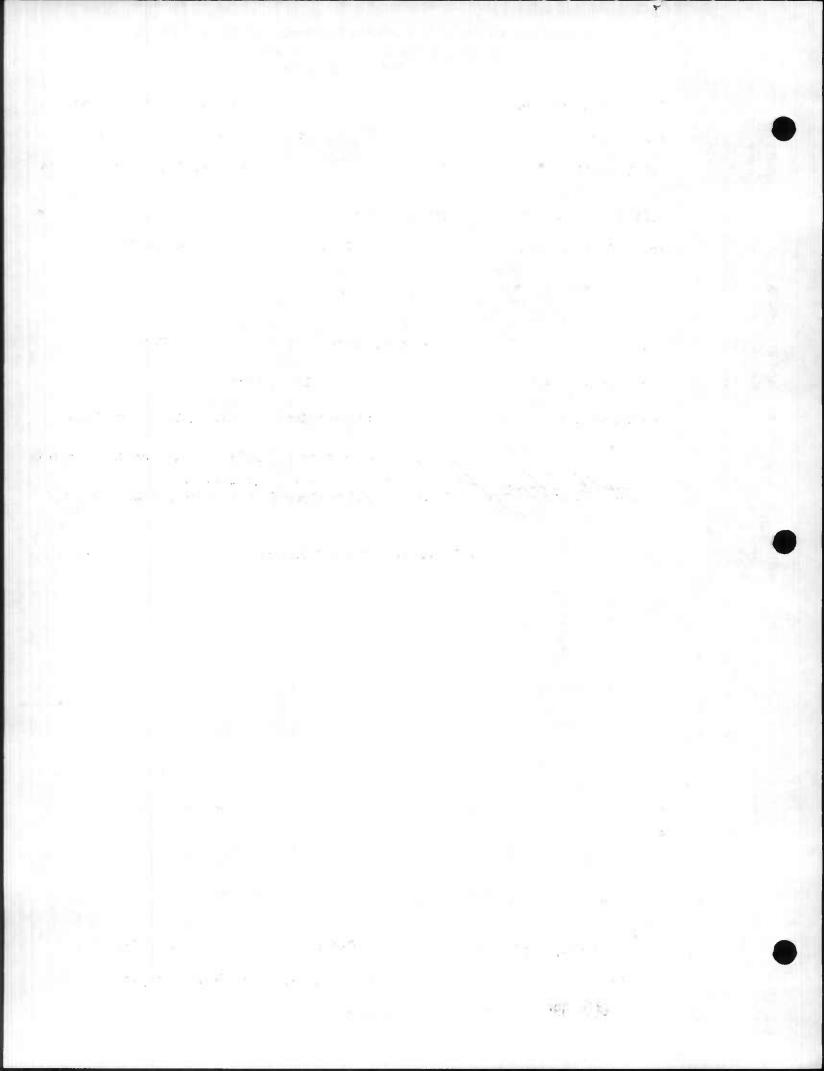
NAME: MYLIAYH JANAE HERBERT



State of Maryland / Department of Health and Mental Hygiene

Physician	1.1	Decedent's Neme (First, Middle, Last)		Ochline	ate of Death	2. Dete of De	Reg. No.	3. Tima of I	
	Н	Frederick John I						18, 199		
/Medical Examiner	40	Fecility Name (If not institution, give				4b. City, Town,	or Location of Deet			
LAGITHIE		19800 Tippett Ro	oad			Lexingto			Mary's	
uneral Pirector		Sociel Security Number 160-28-4899 del Residence of Decedent	X 7. Age	60	Yrs. If Uni	der 1 Year If Under 24 Hours M	Irs. 8. Dete of Bi (Month, Detection) June 9	1938	9. Birthplece (Steta or Country) Pennsylvani	
ž =	-	a. State 10b. County		10c. City, To	own or Location				10d. Inside City	
48 P	M	Maryland St. Mar	y's	Lexi	ngton Pa	rk			1 🗆 Yes	
23a or 28 an band	100	e. Street end Number 19800 Tippett Ro	oad		10f.	Zip Code 20653		10g. Citizen of W United		
Examines 23a or 28e-f show Examines must be notified at 1 by Funeral Director	11.	Maritei Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ■ Yes 2 □ N if Yas, Giva Yeer or Dates:			cedent of Hispanic Origin? pecify Cuban, Mexican, Pu c 2 III No Specify:	(Specify Yes or No erto Rican, etc.)	Blec	4. Rece - American Indien, Bleck, White, etc. Specify: White	
"natural", adrea Ex		15. Decedent's Edu (Specify only highest grad	cation le completed)	1	6a. Decedent's U	suel Occupation work done during most of a T usa ratired)	working	16b. Kind of Bu	siness/Industry	
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em 27 is		Martha Heubel,	Wife		19800 Ti	ippett Road,	Lexingto	n Park,	MD 20653	
item 27 other ti	200	a. Method of Disposition		20b. Place	of Disposition (f	Neme of or other piece)	Date	20c. Location -	City or Town, Stete	
ortant: if he injury or o		1 ☐ Burial 2 ■ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				Crematory	3/23/99	Alexand	ria, Virgi	
important: any injury zissa.	21	Signature of Funeral Service Lines	home of	M0115	Brin	end Address of Fecility nsfield Funer 55 Hollywood			m MD 2065	
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death March 26, Day 1999 8:00 p.m. Charles Joseph Harrison 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 48950 St. James Church Road Lexington Park | Under 24 Hrs. | 8. Data of Birth Hours | Min. | Month, Day, Yaar) | March 15, 1931 Birthplace (Stata or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Days 1 M 2 □ F Months 68 213-28-4268 Maryland Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 BNo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 United States 48950 St. James Church Road Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Evar In U.S. Armed Forcas? 14. Race - Amaricen Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Nes 2 No 1 ☐ Yes 2 ■ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: 1969-1975 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) College (1-4or 5+) Elementery/Secondary (0-12) Noncommissioned Officer Defense 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Neme (First, Middla, Last) Lavina M. Shippley Charles Joseph Harrison, Sr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 48950 St. James Church Road, Lexington Park, MD 2065B Bertha C. Harrison, Wife 20b. Place of Disposition (Nama of cematary, cramatory or other piece) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spage Evergreen Memorial Gardens 3/31/99 Lexington Park, MD 22. Name and Address of Facility 21. Signatur Brinsfield Funeral Home, P.A. Brinsfield, Edward N. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due toffor as a consequence of: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Ware autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 No. 1 🗆 Yes 26. Place of Death (Check only ona) axaminer? axaminerr 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

mast be notified at

"naturel", or items

ir than 'natur

7 is marked other treumatic event,

or other t

Department of Important: If any Injury or

Directo

Funeral

by

Completed

Be

Pages 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health and Mental Hygiene. Int: If them 27 is marked other than "naturel", or frems 23s or 28s-f show

altimore, Maryland 21215-0020

/Medical

Examiner physicien and s the burial-transit Physician/Medicai ettending p signed by ti by been sig Completed hes s certificate he director, Be Certification: To

The law requires that the deeth certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital Attending Physician:

this funeral After To the Hospital or Attendit within 24 hours effer death.
To the Funeral Director: All completaly filled in by the fu death.

25. Wes cese referred to medical

27. Manger of Death 1 Natural 2 Accident

3 ☐ Suicide 4 T Homicide

MAR

29a. Certifies

5 Pending investigation 6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes

28d. Describe how Injury occurred

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stete)

Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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**Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the

29c. Licensa number

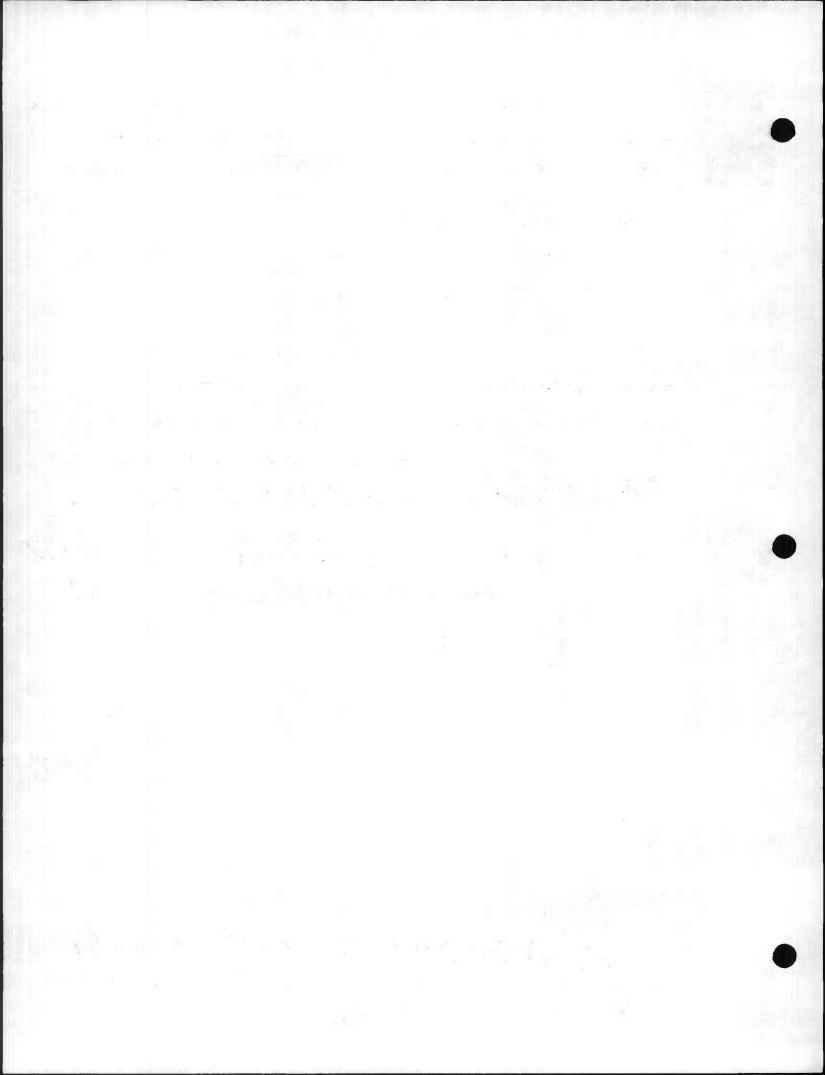
29d. Date signed (Month, Day, Year)

30. Name and adds repleted cause of death (Item 23a) (Type, Print) Jarboe M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 James

th, Day, Year 31. Date filed (Mo 32. Registrar's Signature

State Registrar

edicai



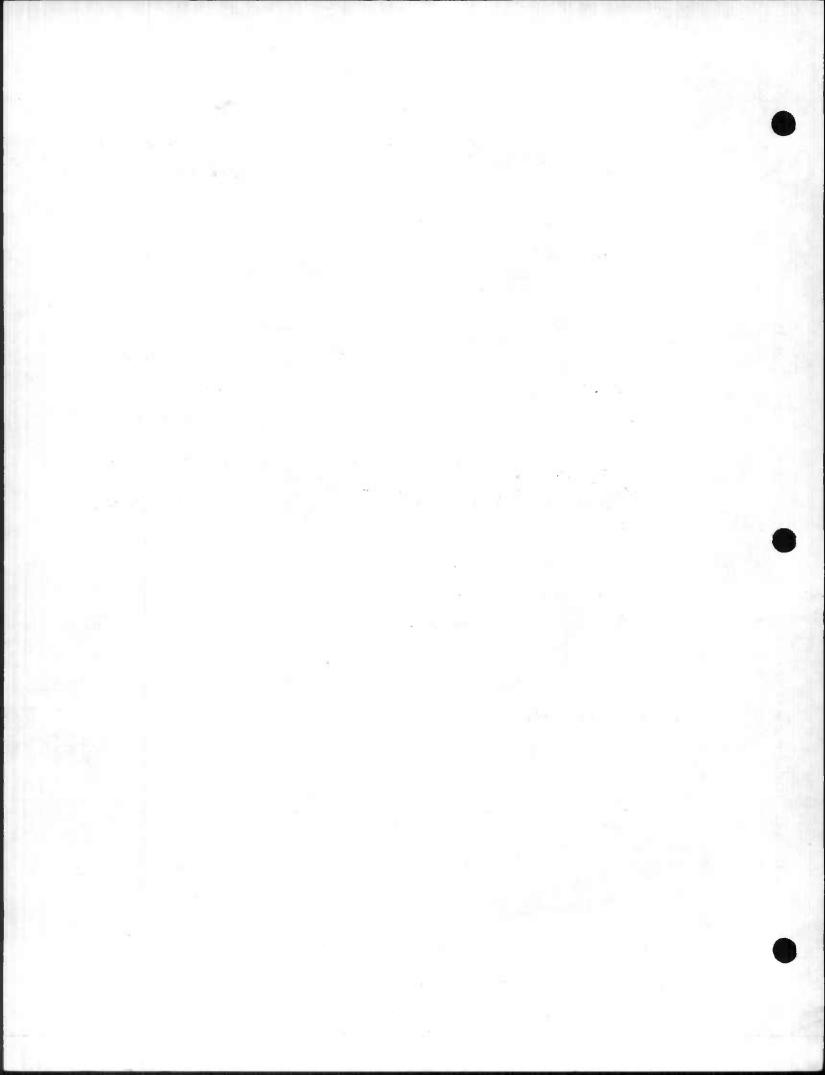
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Mona Caroline Hershberger Mar 2 1y 1:10 am /Medical 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kitzmiller Garrett 927 State Street If Undar 1 Yaar 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 8. Data of Birth Month, Day 2 ear 1943 9. Birthplaca (Stata or Foraign **Funeral** 1□M 2■E Months Days Hours 56 Yrs Director 218 40 3021 Usual Rasidanca of Decadent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, tra Medical Examiner mant be notified at 10d. Insida City Limits Kitzmiller Md Garrett 1 Tas 2 No Director 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? USA 21538 927 State Street death Funeral 11. Marital Status 12. Was Dacadant Evar in U,S. Armed Forcas? Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Race - Amarlcan Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours efter begartment of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Examinati 1 ☐ Navar Marriad 2 ☐ Marriad 1 ☐ Yas 2 M No Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: þ 3 ☐ Widowad 4 N Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elemantery/Sacondary (0-12) College (1-4or 5+) Manufacturing Assembly Line 12 17. Fathar's Nama (First, Middla, Last) 18. Molhar's Nama (First, Middla, Maidan Surnama) Be Helen Tasker Woodrow Harvey 2 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Kitzmiller, Md PO Box 432 Helen Harvey 20b. Placa of Disposition (Nama of camatary, crematory or othar placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata Mt. Zion Cemetery Mar 24 99 Mt. Zion, Md 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funaral Servica Licenaea 22. Nama and Addrass of Facility 3 wdock David A. Burdock FH arid 23a. Part I. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 21538 Kitzmiller, Md Approximata Intarval Batween Onsat and Deeth **Physician** /Medical Immediate Causa (Final ischemic cardiomyopathy disaasa or condition rasulting in daath) years Examiner Dua to (or as a consequence of) Examiner The law requires that the deeth certificete be executed bunial-trensit Sequantially list conditions, if any, leading to Immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avents rasulting in death) Last pue Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Dua to (or as a consequanca of) attending Po P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Tes 2 No 3 Probably 4 Unknown polymyositis Records, Be Completed by 8 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to peeu completion of cause of death? certificate hes page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Assidance 6 Other (Spacify) 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this s efter death.
ii Director: After this
ed in by the funeral d 27. Mannar of Death 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Pi within 24 hours efter death. To the Funeral Director: After th completely filled in by the funera Medical Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 ■ Natural 2 ■ Accidant 5 Pending Investigation 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 3 ☐ Sulcida Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29e. Certifier 1 Cartifying Physicien: To the best of my knowledge, death occurred at tha time, dete end piace, and dua to the ceusa(s) and menner es stated.
 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) 29b. Signatura and titla of cartifian 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar) 30. Nama and address of pelson who complated cause of death (Itam 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550 31. Data filed (Month, Day, Year) WAR 2 3 1999 32. Ragfstrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	1.0.55							
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9 E.		y, Town or Location		10d. tnside City Limits							
Vary e she	Manuland Washington Wil	lliamsport		1 □ Yas 2X No							
or 28s-f s be notified	Maryland Washington Wil	10f. Zip Code	10g. Citizen of Who	et Country?							
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ar death with the Maryla Nerra 23s or 23s-f show ner must be notified at Unneral Director	11. Marital Status 12. Was Decedent Ever in U.			American Indien,							
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C = 01 F	Betty Lou Henson/Wife	312 W. Howard St. Hage	erstown,MD 21740								
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altimore, mil. Pages 1 a partment of Hea portant. If Nem y Injury or othe		ar Lawn Mem.Park Mar.15	,1999 Hagersto	own, Maryland							
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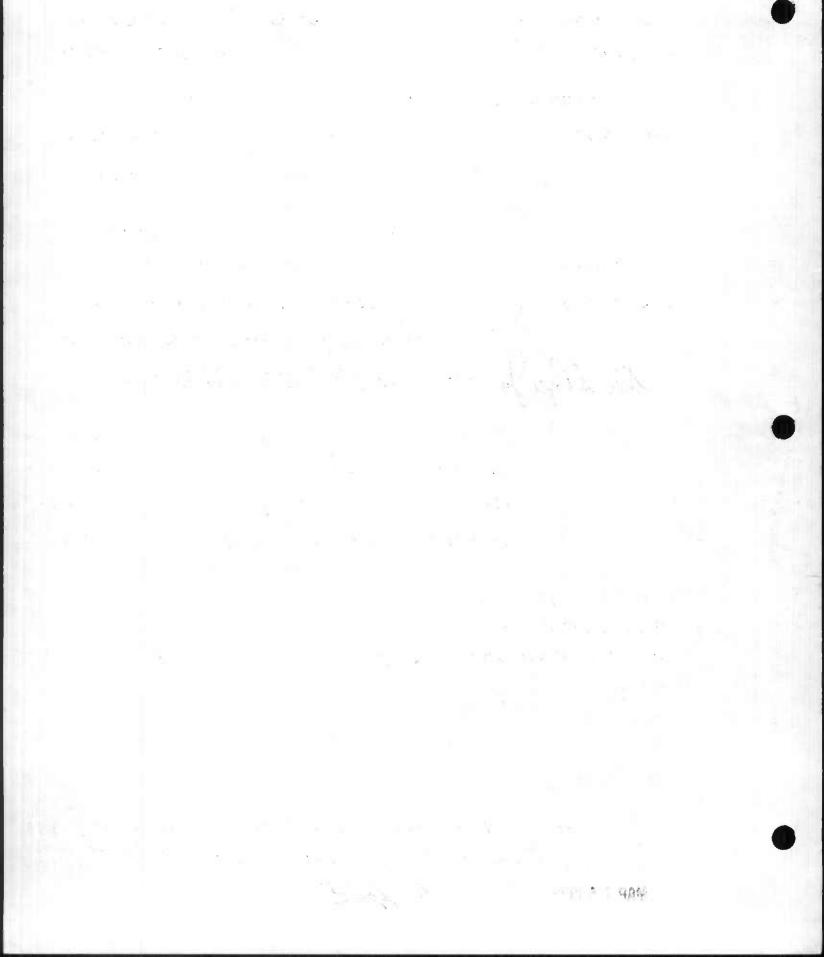


State of Maryland / Department of Health and Mental Hygiene 9 9

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Nith of B	D	10e. Street end Nu					10f. Zip Cod					Citizen of Whet Country? UNITED STATES		
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Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland spearment of Health and Mental Hygiene. mportant: If item 27 is marked other than "naturel; or items 23s or 28s-f show my injury or other traumatic event, the Medical Exertiter traut be inclifted at more.	Be Completed by Funeral Director		rried 2 Marr	ied 1 Yes	orces? 2000 ive		Ves Decedent f Yes, specify (Rican, etc.)		ck, White,	etc.	
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** JENNIE L. JOYNER 2:10 PM March 16 1999 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Gladys Spellman Nursing Home Prince George's Cheverly 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1□ M 2☑ F 88 Director 579-80-0797 May 25, 1910 South Carolina Usuel Residence of Decedent with the Maryland 10a State r 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or edical Examiner must be 20744 2525 Corning Avenue, Apt #3 U.S.A. Peges 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural; or items 23, mrs of the traumatic event, in a Medical Emains many or other traumatic event, in a Medical Emains man. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0020 1 Ves 2 No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th College (1-4or 5+) Housekeeper Private 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Goodwin Mary Love Thoms 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 2525 Corning Avenue, #3, Fort Washington, MD 20744 Lorraine Eve/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 03/20 1 X Buriel 2 Cremetion 3 Removel from State permit. Pege Department of Important: If any Injury or pnce. 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 1999 Suitland, Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility J. B. JENKINS FUNERAL HOME Nana ter 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician neumonia /Medical 2/0-Immediate Cause (Finel disease or condition Examiner Due to (or es e consequence of): Examiner thet the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the multi. informed 1 Yes 2 PNo 3 Probably 4 Unknown denne 2 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 W LED & s certificate hes director, page 2 1 ☐ Yes 2 ☐ No 1 TVes 2 No al or Attending Physician: The sefter deeth.

I Director: After this certificated in by the funeral director, pe 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 2 1 No 1 ☐ Yes 27. Menney of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours o 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) Medicai 29a. Certifier end manner stated. To the Zwithin 2 To the Complete 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 025077 Du 1th

State Registrar 31. Date filed (Month, Day, Year) MAR 1 9 1999

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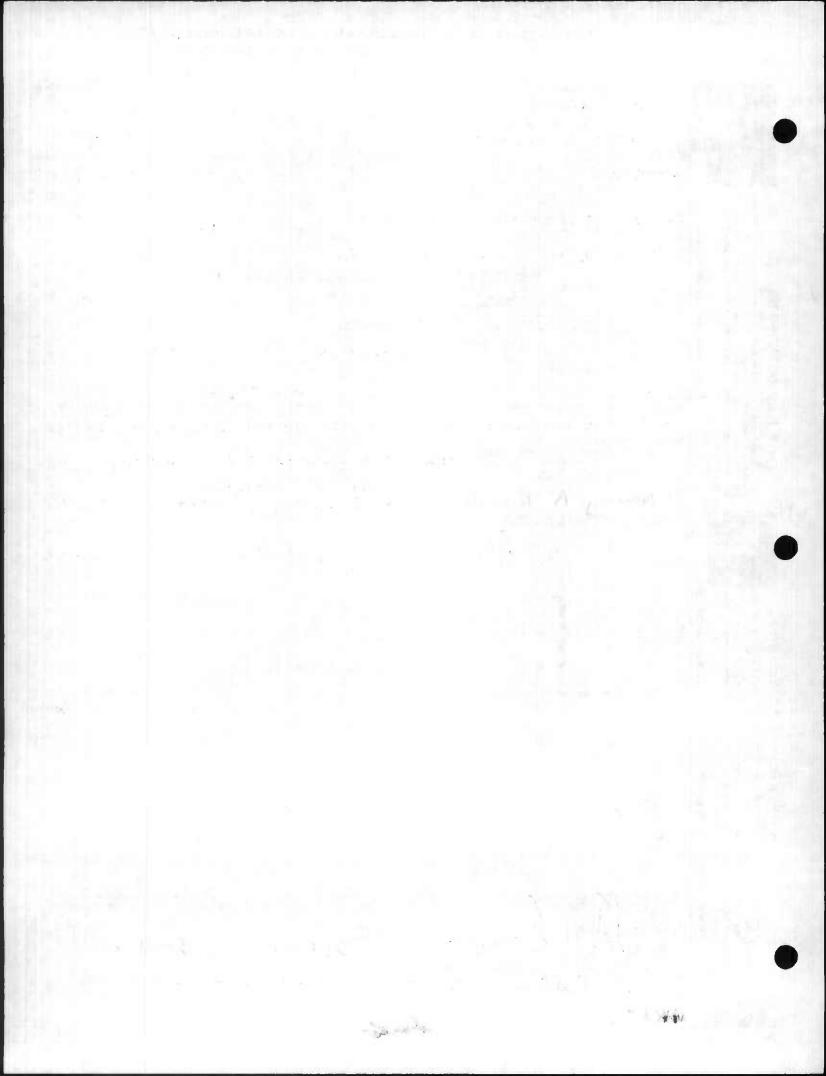
32. Registrer's Signeture

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d other event, Be Cc	8th 17. Fathar's Nema (First, Middla, Last)				Circa	18. Mother's Nam	e (First, Middla,					
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E S I	Unknown 19a. Informent's Name/Raiationship (Type, Print) Michelle Martin/Step-Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
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Department of Heal Important: If Item 2 any Injury or other once.	1 ☐ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify			nt. Valley			03/22 1999					
	21. Signatura of Funaral Service Licens		110000		1		Annandale, Virginia					
2 2 3	Nancy A. Percentie J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryla											
	23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one cause on each line.											
ysician Medical aminer	Immediata Causa (Final disaasa or condition rasulting in daath)	. Ade	- CANC	noc		of he			L.	at and Death		
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physician and s tha burial-transit edical Examiner	Sequantially list conditions,	b	Dua to (or as a	consequance o	ice of):							
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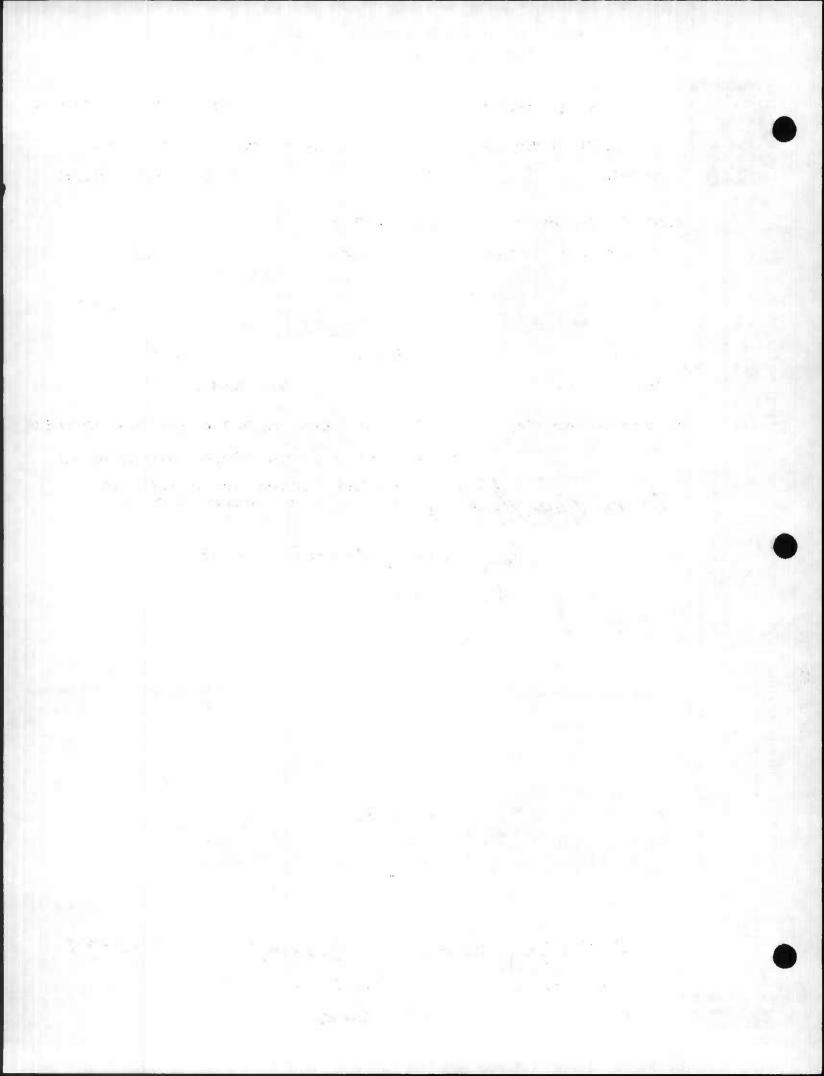


State of Maryland / Department of Health and Mental Hygiene

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Deportment of Health and Mantal Hygiene. Important: if item 27 is marked other than any injury or other treumetic event, the Mantal Bonce. To Be Complete.		21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility. Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650															
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JONES, FRANCIS



State of Maryland / Department of Health and Mental Hygiene

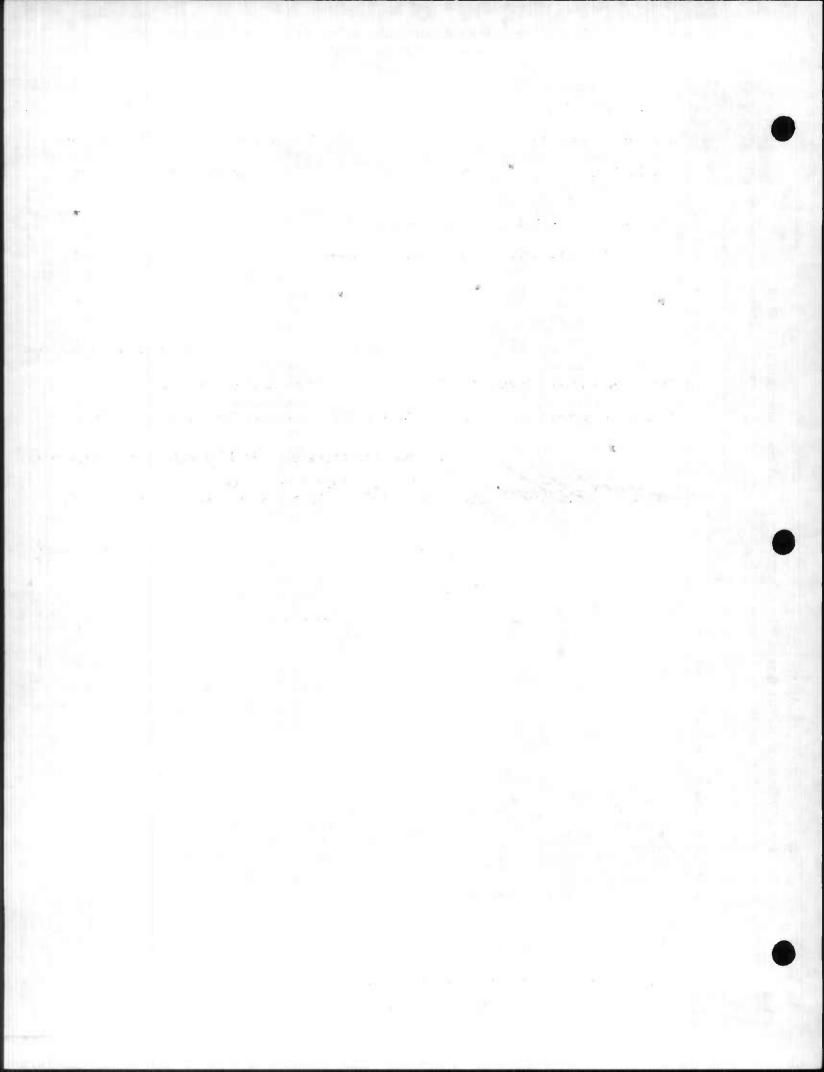
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** 9:00p.m. Esther Marie Johnson March 15, 1999 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months 1 □ M 2 F Yrs. 340-20-5495 93 August 15,1905 Director Illinois Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits x 28a-f ahow a notified at ahow 1 Tes 2 □ No Director St. Mary's Maryland Leonardtown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiena. Important if Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examinat 22680 Cedar Lane Court, Apt. 1-315 20650 United States Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ■ No
If Yes, Give
Yeer or Detes: 14. Rece - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ■ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) College (1-4or 5+) Librarian Department of Defense 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Ferdinand Christopherson Hannibal Anna Marie Engedahl 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) John A. Johnson, P.O. Box 2291, Patuxent River, Maryland 20670 Son 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriet 2 ■ Cremetion 3 ☐ Removel from State 3/21/99 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugeral Segrice License 22. Name end Address of Fecility
Brinsfield Funeral Home, P.A. L Thompson, Jr Ronald M01154 22955 Hollywood Road, Leonardtown, MD 20650 23e. Pert1. Enter the disease, or complications in a caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause a mach line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final diseese or condition resulting in death) SEP 815 /Medical Examiner Examiner nearly preuman 9 physician and the burial-transit that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest ince Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 88 USB signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings evallable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? s cartificata has b 1 Yes 2 No Hospital or Attending Physician: tha funaral director, Be 25. Wes cese referred to medicet exeminer? 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA Certification: To Aftar this 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 5 Pending Investigation 1 Naturel 1 Tes 2 No 2 Accident aftar death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only one) 2 Nedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 47066 3-16-90 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Avani D. Shah Hollywood, Md. 20636 32. Registrer's Signeture

Registrar

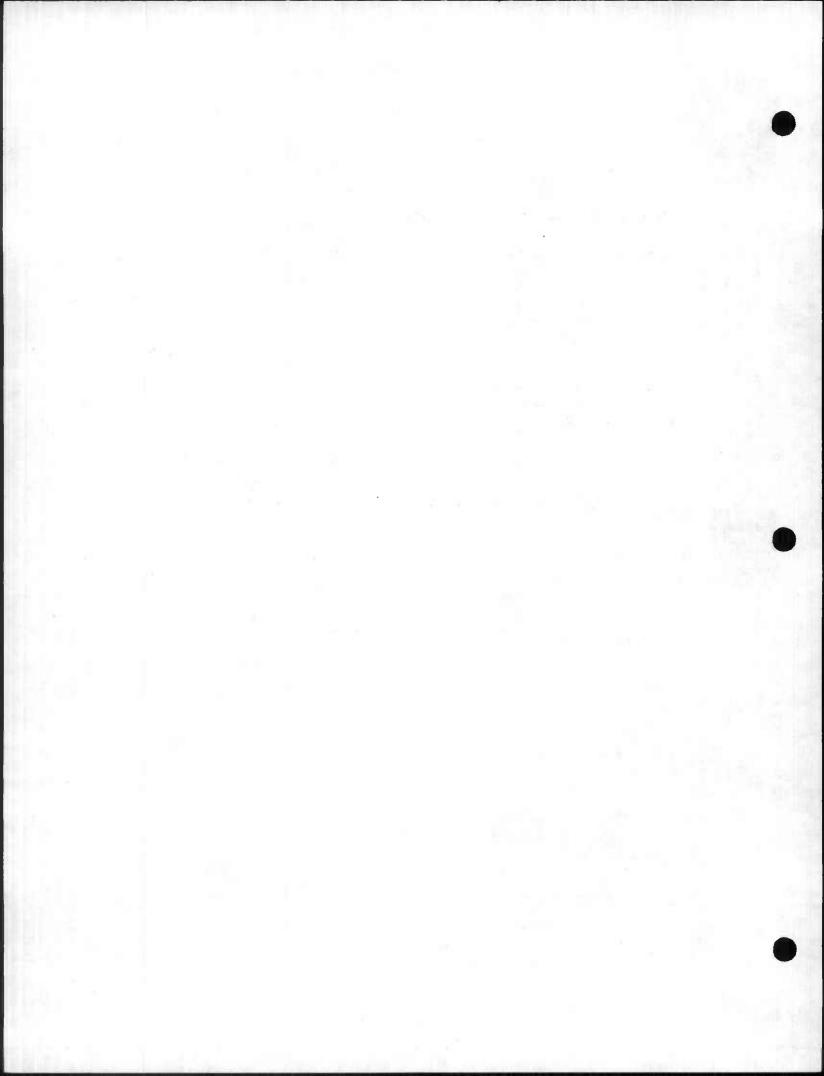
1999

ESTHER MARIE JOHNSON



State of Maryland / Department of Health and Mental Hygiene

-			Certif	icate of	Death		Reg. No.	10201
Physician	Decedant's Name (First, Middle, Last)					2. Dete of De Month	ath Day Yea	3. Tima ot Death
/Medical Examiner	William Ric 4e Fecility Neme (If not institution, give street		on Sr.	4	lb. City, Town, or	MARCA Location of Deet		
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Funeral Director	5. Social Security Number 219-34-9187 Usuet Rasidence of Decedent	7. Aga (līn yrs. l		Under 1 Yaar onths Days	If Under 24 Hr. Hours Mir	. (Month, Da		Birthplaca (Stata or Foraign Country) Lrginia
and and	10a. Stata 10b. County	10c. City	, Town or Location	on				10d. Insida City Limits
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rai', or thems 23a or 28a-f show Examiner must be notified at 1 by Funeral Director		Was Decedent Evar in U, Armed Forces? I XYes 2 ☐ No It Yas, Giva Year or Datas:	If Ya	Decedent of His, specify Cubs		Specify Yas or No rto Rican, etc.)	14. Race - A Black, W Specify:	mancan Indian, hita, atc. White
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7 7 8	Mary Johnson/Spouse		P.O. Bo	ox 52,	Coltons	Point, M	D 20626	
7 2 0	20a. Method of Disposition	20b. P	lece of Dispositio	n (Nama of		Data	20c. Location - City	or Town, Stata
Department of important: If any injury or one.	1 ☐ Burlal 2 【XCramation 3 ☐ Remo 4 ☐ Donation 5 ☐ Othar (Specify)	IVALITOR STATE	ropolita			3/30/99	Alexandri	ia, VA
physician and serious to the bune-transit and serious to the bune-transit serious to the bune-transit serious to the bune-transit serious to the bune transit serious transit	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last	Paule Dua to (or	r as a consequan		lyt	PARTIO		DAYS 5 DAYS
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63	1 Yas 2 No Hosp 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	8a. Data of Injury (Month, Day Year)	ER/Outpatient 3 28b. Tima of Injury	28c. Injur Wor	4 U Nursing	-	dence 6 Other (5	Specify)
at Director: After the director of the funeration:	2 Could not be	8a. Placa of Injury - At ho building, atc. (Specify	ma, tarm, street,	factory, office		28f. Location (City or To		r Rural Routa Number,
within 24 hours after death. To the Funeral Director: After tompletaly filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinet and mannar stated.						
To the comp	29b. Signature and title of certifier			29c. Licens	e number		29d. Data signed (M	onth, Day, Year)
	Jaller Tiller		>	D 18	551		Meko.4	28 1999
	30. Nema and address of person who compt	ated causa of death (Itam	23a) (Type, Prin	it)			1	18 1999 mb 2091
State Registrar	31. Data tiled (Month, Day, Year) MAR 3 0 1999	32. Registrar's Signat	tura 2	Spork		Akso	na tack	m) 209



99-1725-043 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene TRAVIS Certificate of Death JENKINS ITEM: #23 PART I, PER MEO G771 5-17,199 WR. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Yea **Physician** Travis Charles Hayes JENKINS 1999 MARCH 20. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL Hagerstown WASHINGTON If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1♥M 2□F Months Hours Yrs. Director 212-41-8203 Maryland Usual Residence of Deceden the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahona Directo 258-1 Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b hems 23a 11334 Rock Hill Road 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 ZNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 XNever Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White "natural". Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Kindergarten Student Student 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å 8 Department of Health and Mental Important: If them 27 is marked or any injury or other traumatic eve Pages 1 and 2 should Showalter Charles Jenkins Mary Ruth Myers 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary R. Jenkins - Mother 11334 Rock Hill Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/26/99 Hagerstown, Maryland 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 muc 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) SEPSIS Wo Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical for use as U88 detached signed by the

à Completed Be Certification: To

resulting in death) Last	d	or):		
Part II. Other significant conditions of	contributing to death but not resulting In the underly	ing cause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknown
		_	24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 \sum No
25. Was cese referred to medical examiner?		26. Place of Dee	eth (Check only one)	
Yos 2□ No	Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing H	lome 5 ☐ Residenca 6 ☐ Oth	er (Specify)
27. Manner of Death 1 Netural 5 Pending investigation		28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined		ctory, office	28f. Location (Street and Numb City or Town, Stete)	per or Rural Route Number,
	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investige and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date signe	d (Month, Day, Year)

State Registrar

edical 3

30. Name and address of person who completed

MAR 25

1999

THEODORE MIKE 31. Date filed (Month, Day, Year)

32. Registrar's Signature

se of death (Item 23a) (Type, Print)

no

111 Penn Street, Baltimore, Maryland 21201

MARCH 24, 1999

OCME

3. Time of Death

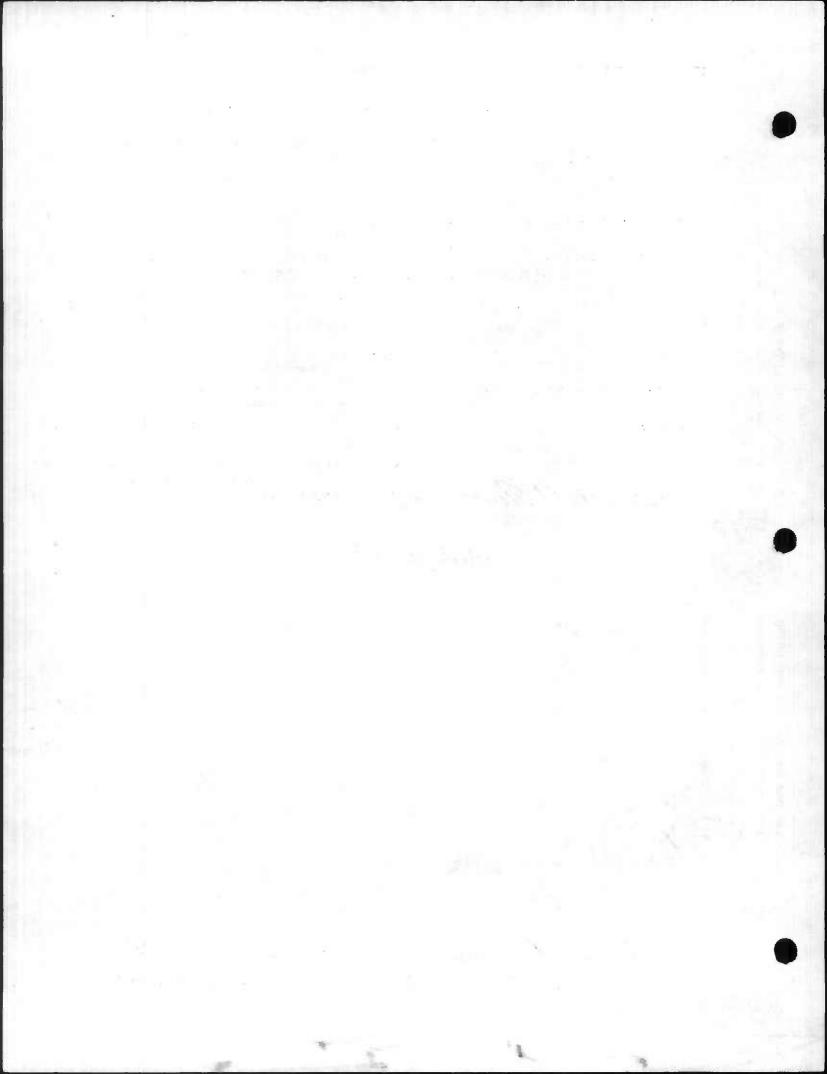
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1 ☐ Yes 2X No

To the Hospital or Attending Physician: within 24 hours after death.

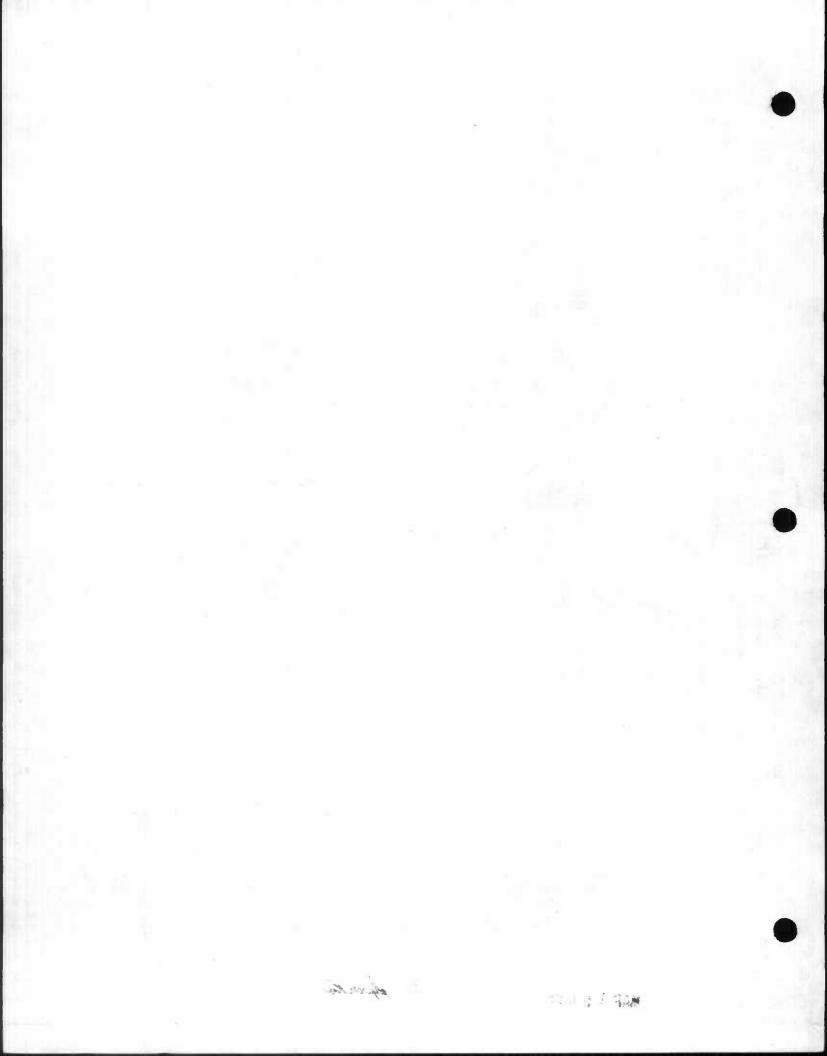
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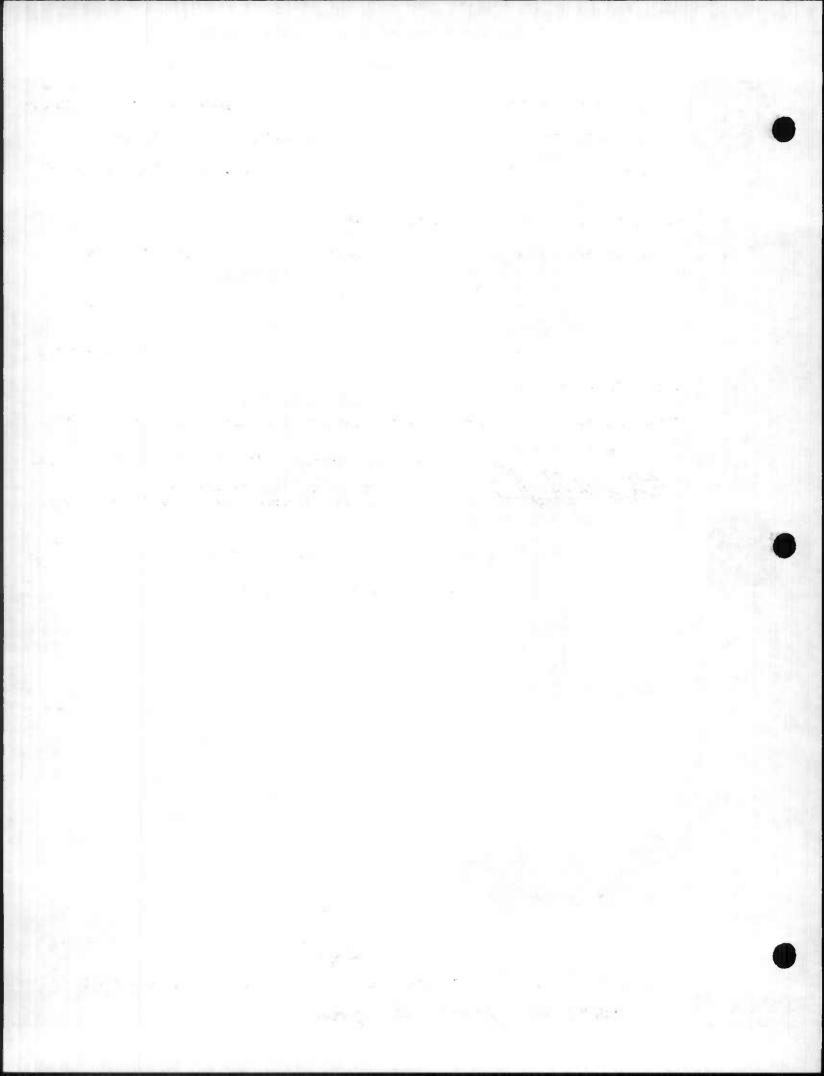


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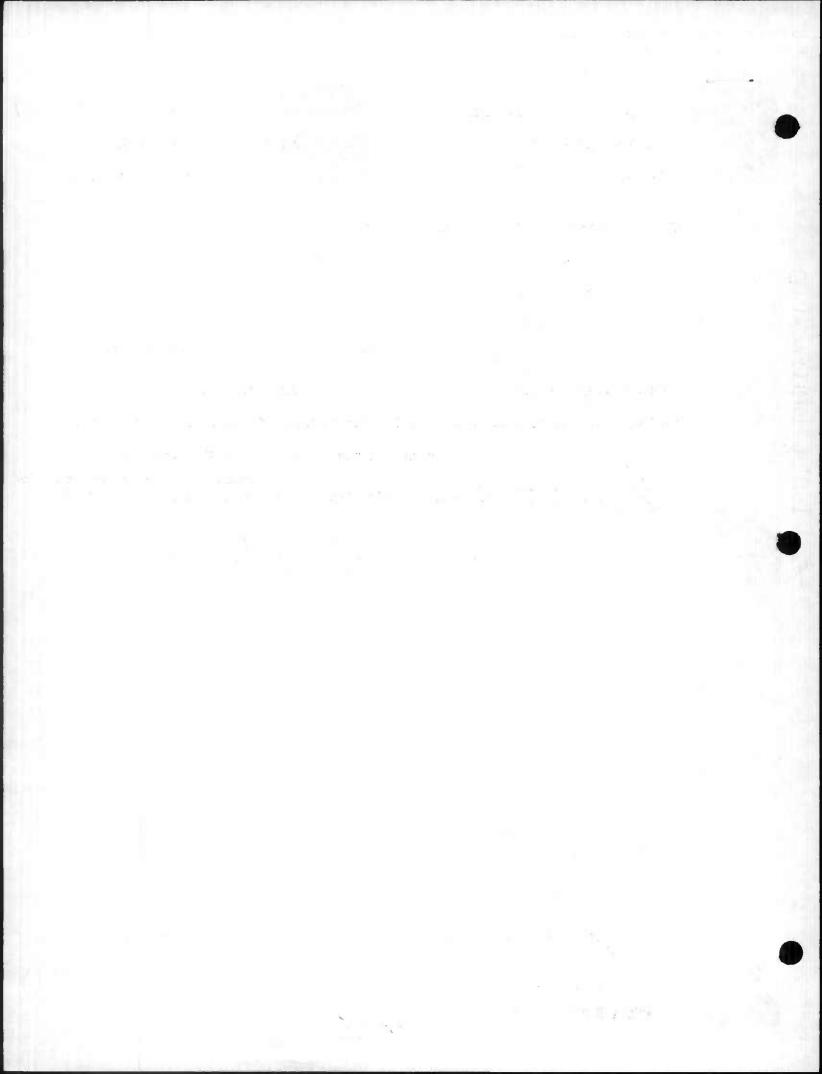
				Certifica	ate of	Death			Reg. No.			
	1. Decedent's Name (First, Middle,	Last)						2. Date of De			3. Time	of Death
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/Medical	4a Facility Name (If not institution,		7)			4b. City, To	own, or L	ocation of Deet			3.4	ro an
Examiner	Sunrise Center		,		5	Elkto			Ceci	1117-		
		Sex 7. A	ge (In yrs. last bir	tholout If Uni	der 1 Year			P Date of Ric			ann (Ctat	o an Casaisa
Funeral	217-18-2349	1□M 2ØF		Yrs. Month			Min.	8. Data of Bir (Month, Da	y, Year)	Countr	(Y)	e or Foreign
Director	Usual Residence of Decedent		/3					reb. Z	6, 1924	Mary.	Tand	
pu a	10a. State 10b. County		10c. City, Town	n or Location						10	d Inside	City Limits
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vith the Ma or 28s-f a be notified	10e. Street and Number				Zip Code				10g. Citizen of What Country?			
23a	110 West Red Hi	ll Road		21	918				U.S.A.			
permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. To returned to other traumatic event, the Medical Estimose must be notified at and Injury or other traumatic event, the Medical Estimose must be notified at and Injury or other traumatic event, the Medical Estimose must be notified at and Injury or other traumatic event, the Medical Estimose must be notified at and Injury or other traumatic event, the Medical Estimose must be notified at an Injury or other traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose must be notified at a large traumatic event, the Medical Estimose traumatic event event event event.	11. Marital Status	12. Was Deceden Armed Forces		13. Was De	cedent of I	Hispanic Or	igin? (Sp	ecify Yes or No		ce - America ck. White, e		
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d 2 should be flie if h and Mental Hy ?? Is marked other traumatic event	19a. Informant's Name/Relationship								er, City or Town			
end n 27	Barbara K. Bruc	e - Daughte				Hill	Roa	d, Cono	wingo, 1	4D 219	18	
-156	20a. Method of Disposition		annata.	Disposition (f	Vame of or other pla	ice)	1	Deta	20c. Location	· City or Tow	vn, Steta	
mit. Peges 1 er partment of Hea portant: If Item 3 y Injury or other	1 A Burial 2 ☐ Cremetion 3 Donation 5 ☐ Other (Spe			Lincoln	Cem	eterv	0	3/15/99	Brentwo	ood. M	larv1	and
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Examiner	resulting in death)	a	Due to (or as e o	7 64	s.					- 1	10,	
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Physician: this carific ral director.	1 Yes 2 No	Hospital: 1 Inpat	ient 2 ER/Ou	tpatient 3	DOA OI	her: 402Ni	ursing Ho	oma 5 Rasi	idence 6 Ott	ner (Specify)	
or Attanding Physical death. Director: After this in by the funeral of the funer	27. Manneyof Death	28a. Data of Inj (Month, D	ury 28b. 1	ime of	28c. Inju				how injury occur			
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tal or Attanding Phy as Director: After this led in by the funeral Certification: T	3 ☐ Suicide 6 ☐ Could not	A ZOB. PIRCE OF IF	njury - At homa, fa	rm, street, fect	ory, office			28f. Location	Street and Numi	ber or Rural	Routa N	umber,
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0 000	29b. Signature and title of certifier	0 1-0	0		zyc. Licen	se number			29d. Date signe	id (Month, D	Jey, Year))
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m	30. Name and address of person wh	o completed cause of	death (Item 23a) (Type, Print)			_	- Eton ML				
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Funeral Director	5. Social Security Number 333–14–2215		Age (In yrs. lest birth	day) If Un Month	der 1 Year ns Deys		8. Dete of Bir		9. Birthpl	lece (State or Foreign try)
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Maryland 21215-0020 d 2 should be lifed within 72 hours efter death with the Maryland lith end Mentel Hygiene. Z'I is marked other than "natural", or items 23s or 28s-f show returned event, it a Madical Examination must be inclined at To Bo Complesed by Euroscal Discourse.	11. Maritel Stetus 1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	s? ■ No		cedent of I pecify Cub 2 No	Hispanlc Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- lo Rican, etc.) 14. Race - Bleck, 1 Specify:		k, White,	
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he Hospit in 24 hour he Funera pletely title	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the best Examiner: On the besis end menner	of exeminetion end	deeth occurr or Investigat	ed at the ti	me, date and plece opinion, deeth occu	, and due to the urred at the time,	ceuse(s) and ma dete end place,	anner es si and due to	ated. the ceuse(s)
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	fand mow st		Usual Residence of Decedent 10e. Stete 10b. County		,	, Town or Lo	ocation			12-20	74		d. Inside City Limits
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TE BOOK	urs after de Mr, or Nem	by Funeral	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2010 If Yes, Give Yeer or Detes:			Was Deced If Yes, sped 1 ☐ Yes		lispenic Origin? (S en, Mexicen, Puert Specify:	pecify Yes or No o Rican, etc.)		ck, White, e	itc.
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9	E SEE	To	Edward Leigh H 19a. Informant's Name/Reletionship			19b. Mailir	ng Address	(Street	Annie e <i>nd N</i> um <i>ber</i> o <i>r R</i> u	O. Davi:		State, Zip (Code)
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BILL	permit. Pa Departmen Important: any Injury once.		21. Signetury of Funeral Service Lio	**	l				ss of Fecility S				ervices, PA 20748
CR	Physician /Medical Examiner	Examiner	Ida. Part Enter the disease, or contact, or heart feilure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	. Meta	Due to (or	es e consec	Daquence of)	e of dyin		Bre			Approximete Intervel Between Onset end Deeth
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ivicion	or Attending Physician: or Attending Physician: offercor: After this certifical in by the funeral director,	Certification:	1 Naturel 5 Pending 2 Accident Investigati 3 Suicide 6 Could not 4 Homlcide	(Month, Dey	Year)	Injury	М		k? Yes 2□No		Street end Numb		Route Number,
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	Sta		31. Dete filed (Month, Dey, Year)	Registre	er's Signeti	ure	1 -						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month 1999 23:23 Norman Lavine March /Medical 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MD Montgomery 5. Social Security Number If Undar 1 Year | If Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, 9. Birthplace (Stete or Foraign 1€M 2□ F Days 1906 Baltimore MD Yrs. 9 577-18-7313 92 Oct. Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince Georges MD Takoma Park 1X Yes 2□ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 804 Larch Ave 20912 USA Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - Amarican Indian, Black, White, atc. 11. Maritel Status totor 2 □ No If Yas, Giva Year or Dates: WWII 1 Never Married 2 Married Specify: White 1 ☐ Yas 2 TNO Specify: by 3℃Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Spacify only highast grade complated) Elamentary/Secondary (0-12) Collega (1-4or 5+) Merchant Retail Store 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Gertrude Roman Joseph Lavine 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 11500 Narin Farmhouse Ct., Silver Spring MD 20902 David Lavine/Son 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition MXBurial 2 ☐ Cramation 3 ☐ Removal from Stata King David Memorial Gard. 3/16/99 Falls Church VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name end Address of Facility Stein Hebrew Memorial FH 232 Carroll St., NW, Washington DC 20012 23a. Part Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiec or respiratory arrest, shock, or leart feilure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth Immediate Causa (Final diseesa or condition rasulting in daath) a Cardio Pulmonary Arrest Minutes Dua to (or as a consequanca of): Examiner Arteriosclerotic Heart Disease Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initieted events rasulting in death) Last Dua to (or as e consequança of): Physician/Medicai Dua to (or as a consequenca of): Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 H Unknown þ 24b. Wara autopsy findings evaileble prior to complation of causa of daath? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical Be 26. Place of Daath (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) P 1 ☐ Inpatiant 2000 ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Deta of Injury (Month, Day Yaar) Medicai Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Panding investigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28t. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner steted. 29a. Certifian 29b. Signature and little of certifier 29c. License number 29d. Data signed (Month, Day, Year) Mass Ave, was 30. Nema and address of person who can d cause of death (Item 23s) (Type, Print)

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital

Funeral

Director

28a-f show must be notified at

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items 23a

traumatic event, the Medical Examiner

Important: It any injury or

Physician /Medical

Examiner

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certificate

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Pages 1 end 2 should be filed within 72 hours efter ent of Heelth and Mentel Hygiene.
If item 27 is marked other than "natural", or fte my or other traumatic event, its Medical Examps

Baltimore, Maryland 21215-0020

the Maryland

To the Hospital or Attending Physician: "within 24 hours efter deeth." To the Funerel Director: After this certifica completely

State Registrar 31. Data filed (Month, Pay, Yaar)

MAR 1 7 1999

3. Registrar's Signatura

18 5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Michael Eugene LeDonne, Sr. MARCH 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth Washington Adventist Hospital Takoma Pa Park Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 15 M 20 F Yrs. 234-09-4788 82 January 22, 1917 Italy Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Piney Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45319 St. George's U.S.A. 14. Race - American Indian, Black, White, etc. Park Avenue 20674 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 NWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Testman 12th Telephone Company 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francesco LeDonne Elizabeth Ricci 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1584 Brass Lantern Way, Reston, VA 20194 Michael E. LeDonne/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐Donation 5 ☐Other (Specify) St. George's Cath. Cemetery 3/20/99 Valley Lee, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, 23a. Part1. Enter the disease, or complications that caused the death point enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Tyes 2 No 26. Piace of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

J Hygiene, other than 'natural', or forms 23s or 28s-f show vent, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

nt of Health and Mental H
I: If item 27 is marked oth
y or other traumatic even

permit. Page Department of Important: If any Injury or page.

Baltimore, Maryland 21215-0020

Examiner

(Check only one)

29b. Signature and title of carrier

Physician/Medicai à Completed director, Be Medical Certification: To

P.O. Box 68760, should be det Records. Division of Vital or Attending Physician: After this death. • Hospital or Attendi 124 hours after death • Funeral Director: ✓ filled in by completely within 2 To the

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Topatient 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

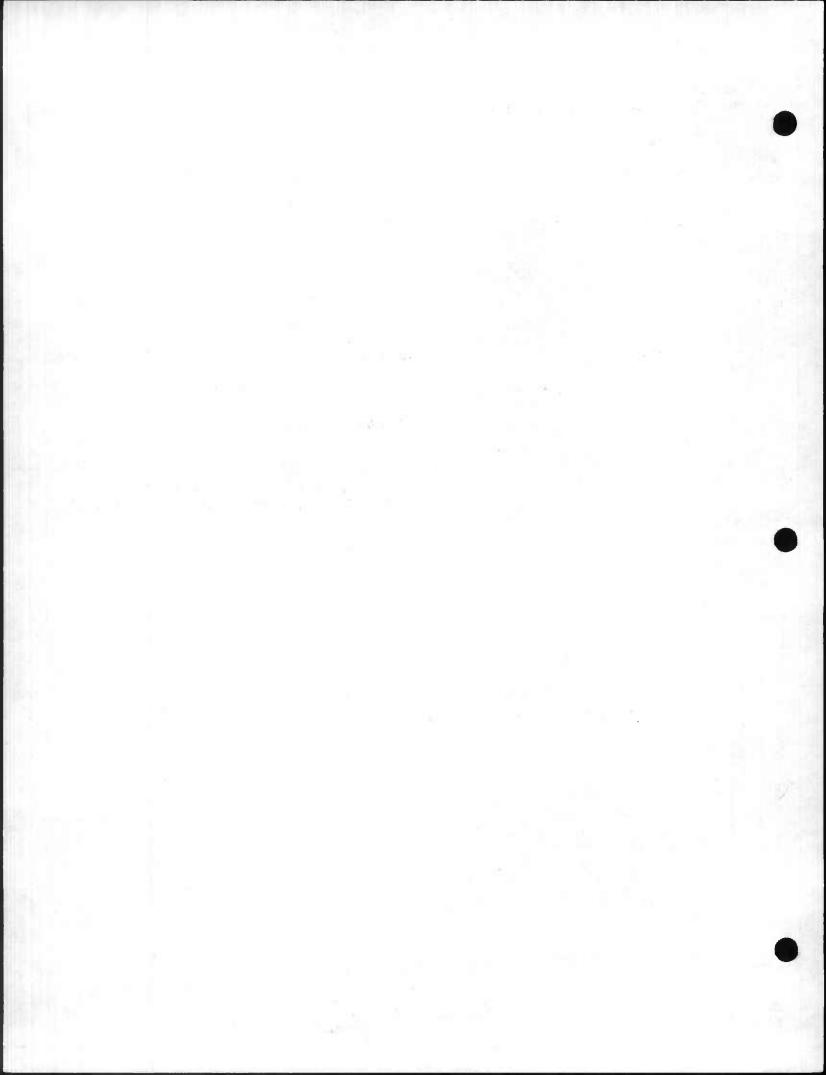
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

TAKOMA PARK Md 20912 7600 CARROLL AVE

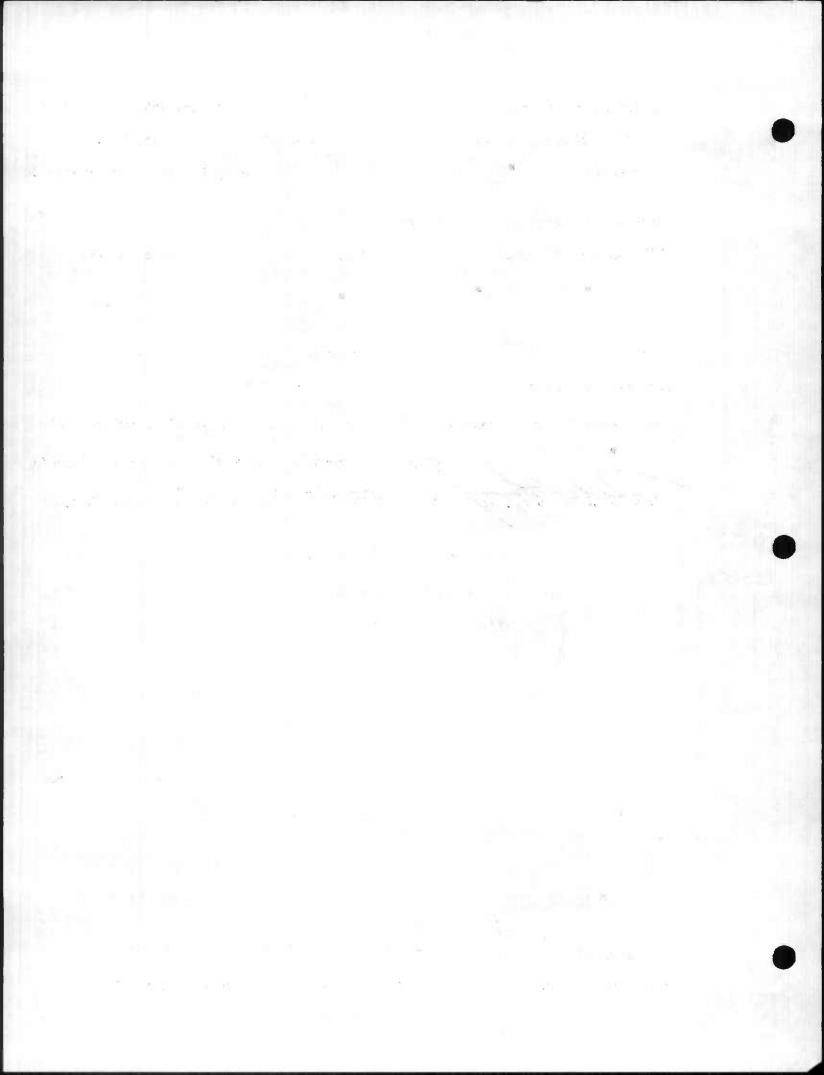
R HETAN TEL

R 1 8 32. Registrer's Signature 1999



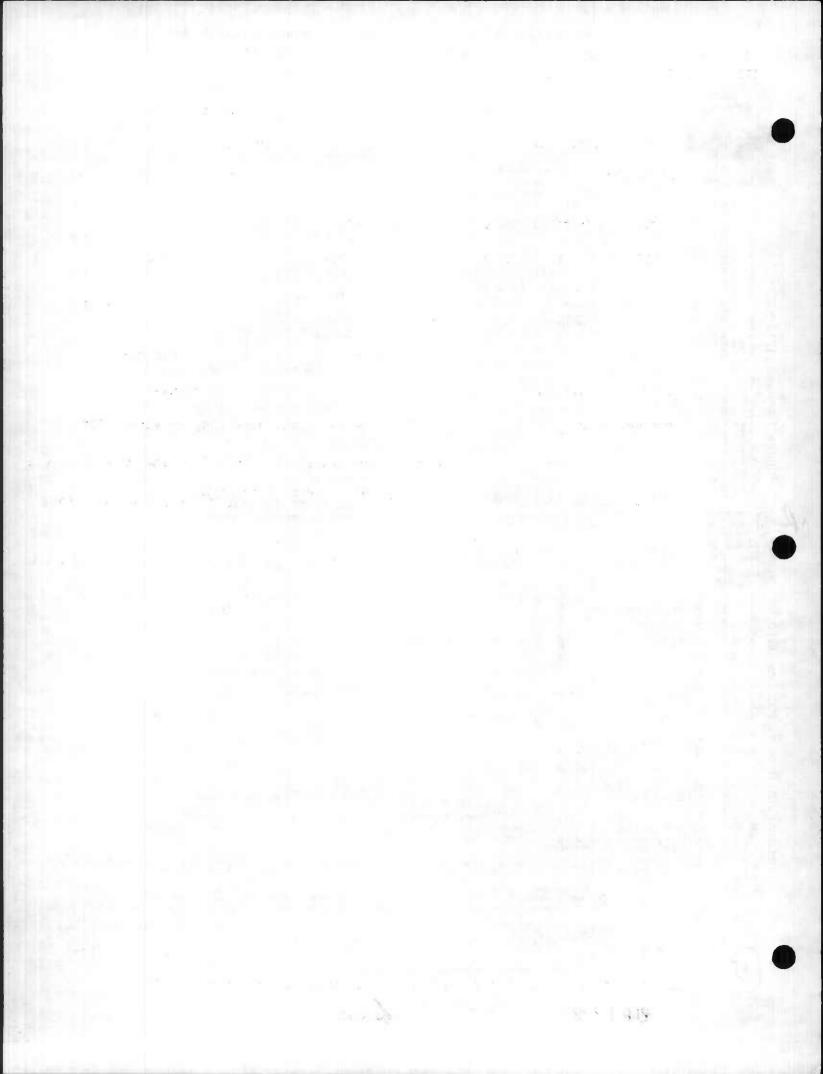
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** March 24, 1999 8:30 AM Fay Kaldenbach Lawrence /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Day, Year) July 16,1912 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1□M 2■F Yrs 577-03-2503 86 Washington, DC Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood reaments event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43676 Drum Cliff Road 20636 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Department: If item 27 is manked other than "matural", or item any injury or other traumatic event, the Medical Event Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife N/A 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 John W. Kaldenbach Hazel Hanna 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) Husband 43676 Drum Cliff Road, Hollywood, Maryland 20636 Frank Lawrence, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ■ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/29/99 Alexandria, Virginia 21. Signature of Funeral Service Licensii 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Ronald L. Thompson M01154 MD 20650 23a. Perfl. Enter the disease, or complications is a clused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Deep venous thromboses /Medical Immediate Cause (Final disease or condition resulting in death) 30 Examiner Due to (or es e consequence of): Immobility in bed Examiner physician and the bunal-transit tha death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Alzheimers Dis Box 68760. Physician/Medicai Due to (or as a consequence of): USB 23b. Did tobacco usa contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings avellable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed peen has 2 No 1 ☐ Yes 2 No certificate or Attending Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral Certification: 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending Investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Mospital of 24 hours a Funeral D 29a. Certifier ī Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manper stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 3/24/99 100000 506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Berube, M.D. 28170 Old Village Road, Mechanicsville, MD 20659 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 25 1999 Registrar



Item 8 Per FH FilmG770 4-16-99 rjaState of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #7 PER F.H. G770 4-8-99 WR. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** March 15, 1999 5:15 pm Claire /Medical 4b City Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Sacred Heart Home Hyattsville Prince George's if Under 1 Year if Under 24 Hrs. 8. Date of Birth 7-19-15 9. Birthplace (State or Foreign (Month, Day, Year) Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2X F Yrs 154-09-8547 81 1917 Pennsylvania Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5805 Queens Chapel Road 20782 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Status filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Peges 1 and 2 should be file Department of Health and Mentel Hy important: If item 27 is marked other any injury or other treumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Ceremsak Susan Ceremsak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Timothy Masick - Son 8801 Damascus Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/17/99 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD J. Dasc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Mursing Home 5 Residence 6 Other (Specify) 2 1 Yes 254No Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Dalural 5 Pending Investigation s after death. 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the ceuse(s) and manner stated. 29a. Certifier Medical ompletaly (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19609 March 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D, 3503 Perry Street, Mt. Rainier, Maryland 20712 32. Registrar's Signatur 31. Date filed (Month, Day, Year)
MAR 1 7 1999 State Registrar



State of Maryland / Department of Health and Mental Hygiene ()

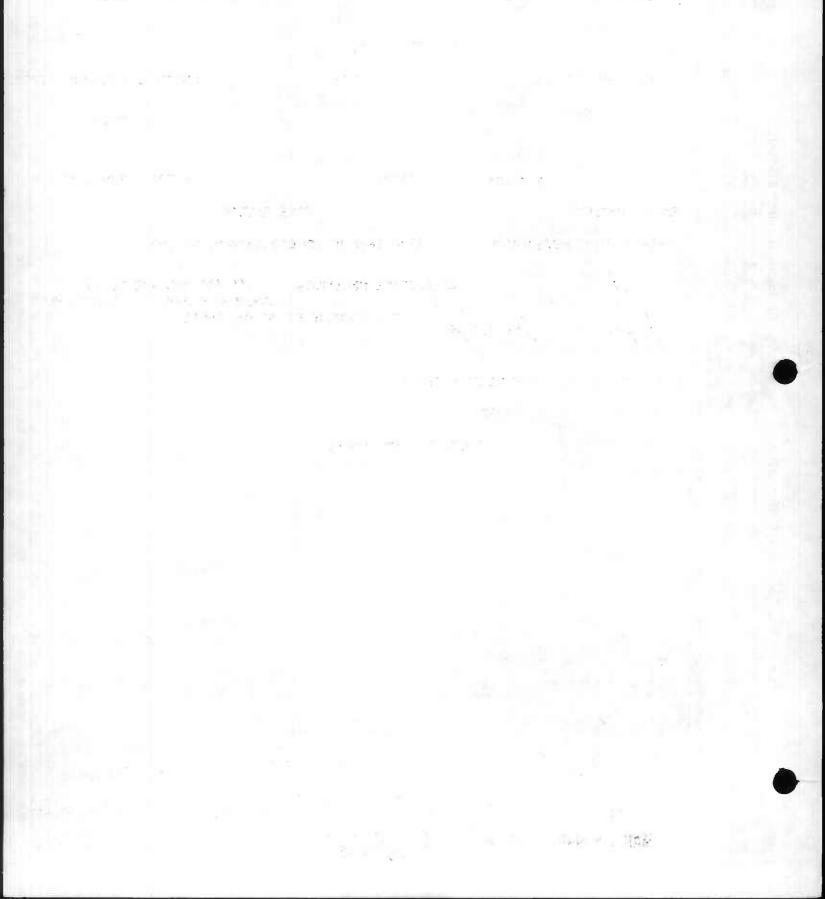
					(Certificate of	Death	F	Reg. No.	185	M5 (M5)
r		77	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	West.	3. Time of Death
	Physici /Medi		Charlotte	Augustus	Jackso	n Matthews	5	March	13, 199	Year	7:15 P.M.
	Examir		4e. Fecility Neme (If not Institution, give	street and number)			4b. City, Town, or I				
			Mariner Health of	Greater	Laure1		Laure1		Princ	e Geor	rges
	Funeral Director		214-32-9058	7. Age	63 Y	day) If Under 1 Year Months Days		8. Date of Birth (Month, Day April 1	0,1935	9. Birthple Country Mary.	ice (State or Foreign Y) Land
	pue M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				100	d. tnside City Limits
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	the 1284	Director	10e. Street and Number	ocorges		10f. Zip Code		1	10g. Citizen of \	What Countr	v?
	3a or		8511 Corona St	reet			747		United		•
	ms 2	Funeral		12. Was Decedent E	Ever in U,S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Rac	e - Americar	n Indien,
Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Modical Evantine must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Dates:	lo	tf Yes, specify Cut 1 ☐ Yes 2 🗶 No	Specify:	o Rican, etc.)		ck, White, etc.	
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2	od wit gien f. me	50	12th grade			Binder Worl	ker		Accoun	ting (Office
pu	al Hard	Be	17. Father'a Name (First, Middle, Last)				18. Mother's Nen	ne (First, Middle,	Maiden Suman	10)	
yla	Menid Menid	2	William		Jackso	n	Sarah			DeMar	
lar	2 sh and and si		19a. Informant'a Neme/Relationship (T)	rpe, Print)	19b.	Mailing Address (Stree	t and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip C	code)
	end eelth 72 T		Sharon Marie Doz	ier (daugl			Street, F				
Baltimore,	Pages 1 nent of H nt: If iten iry or oth		20a. Method of Disposition 1X Burlal 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cemetery	Disposition (Name of crematory or other plant of the crematory				City or Town	m, State Maryland
Balti	permit. Departminents imports any injuited.		21. Signeture of Emeral Service Licens		_	22. Name and Addr	ess of Facility Ro	bert G.	Mason F		
	_		23a. Part1. Enter the disease, or compl	cations that caused	the death. Do no	<u> </u>				-	Approximate
	Physician /Medical Examiner	_	shock, or heert failure. List only of tmmediate Cause (Finel disease or condition resulting in death)	a	S C125,						nterval Between Onaet end Deeth
ox 68760,	eeth certificete be executed attending physician end I for use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Card	Due to (or as a co	mratory	assesî				
Bo	deeth e atte	lcia	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in	the underlying cause of	iven in Part I	23b. Did to	obacco use co	ntribute to t	the cause of death?
, P.O.	iras that the deeth signed by the atte d be deteched for	by Physician							fes 2□No	3 Probe	1.6
Records,	aw requ	Completed b	Decubitus Corcinoma	colon				24a. Was a perfor	an autopsy med?	evail	e autopsy findings lable prior to pletion of cause eath?
		Co						1 🗆 Y	es 2 No	10	Yes 2□ No
/ite	delan: The	Be	25. Wes case referred to medical examiner?					ith (Check only or	ne)		
5	Physician: rthis certific rral director,	L _o	TILI THIS ZIA NO	fospital: 1 Inpatie	nt 2 ER/Out	Ballerit 3L DOA		ome 5 Resid	lence 6 DOth	er (Specify)	
Division of Vital	After fune	atlon:	27. Manner of Death 1 Anaturel 5 Pending 2 Accident Investigation	28e. Date of Injur (Month, Day		ury Wo	ork?] Yes 2 □ No	28d. Describe h	low injury occur	red	
N N	X 2 2 C	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injubuilding, etc		n, street, fectory, office		28f. Location (S City or Tow		er or Rural I	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	nician: To the best oner: On the besis of and menner sta	examination and/	death occurred et the to or investigation, in my	ime, date and placa opinion, death occu	, and due to the c rred at the time, o	cause(a) and me date and place,	enner as stat and due to ti	led. he cause(s)
	withi To th	M	29b. Signeture and title of certifier				se number	2	29d. Dete signe	d (Month, De	ay, Year)
			18muil	ND AI	tendin	9 04	2580		March	16,	1999

State Registrar 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / D

Certificate of Death Reg. No.	ar in	1001
Department of Health and Mental Hygiene		1091

		Cer	tificate of l	Death		Reg. No.	e iunti
1 100 00	Decedent's Name (First, Middle, Last)				2. Date of De Month		3. Time of Death
Physician /Medical	KAREN McCLURE				MARCH :		7:05pm
Examiner	4a Fecility Neme (If not institution, give street end number)		4	b. City, Town, or	Location of Deetl	4c. County of	
	6204 ROCKHURST ROAD			BETHESDA		MONTO	GOMERY
Funeral Director	579-86-4794 1□ M *** 40	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De FEB • 18	v, Year)	Birthplece (State or Foreign Country) JAPAN
Pue ≱	Usual Residence of Dacedant 10a, State 10b, County 10c.	City, Town or Lo	cation				10d. Inside City Limits
or 28a-1 sho		ASHINGTO	1				1 X Yes 2 No
death with the Maryland one 23e or 28e-f show crount be notified at neral Director	1720 16th ST N.W.		10f. Zip Code 20009		Ţ	10g. Citizen of W JNITED S	het Country? FATES OF AMERIC
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ed within 72 hor yrgiene. Yrgiene. The Medical the Medical	15. Decedent's Education (Specify only highest grade complated)	16a. Deced (Give life, L	fent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	rking	16b. Kind of Bus	siness/Industry
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1 end 2 sh Heelth end em 27 is m other traum	JAMES F. BARROWS/HUSBAND	1	16th ST				State, Zip Code)
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permit. Pages Department of Important: If is any injury or ence.	1 ☐ Buriel 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	HESAPEAR	KE CREMAT	ORY	3/16/99	BELTSVII	LLE, MD.
artir. Sorta Inju	21. Signature of Fineral Service Licenses	7 22	. Name and Addre				FUNERAL HOME
89188	23a. Part1. Whiter the disease, or committations that caused the canada shock, or heart failure. List onlytene cause on each time.	page .	16 KENNED				
deeth certificate be axecuted a stranding physician and d for use as the bunal-transit diclan/Medical Examiner	Sequentially list conditions, if eny, leading to immadiate causa. Enter Undertying Cause (Disaase or injury	o (or as e conseq	quence of):				
	Pert II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	en in Pert I.		tobacco use con	tribute to the cause of death?
requires the been signer should be deleted by						an eutopsy ormed?	24b. Were eutopsy tindings aveileble prior to completion of cause of daath?
ate hes page 2					10	Yas 2 No	1 ☐ Yes 2 ☐ No
ysician: The is is certificata he director, page	25. Was case reterred to medical			26. Place of Da	eth (Check only	one)	
Physician: this certifical director, TO Be	examiner? 1 ☐ Yas 2X No Hospitai: 1 ☐ Inpatiant	2 ER/Outpetien	nt 3 DOA Oth	or:	lome 5 Rasi		or (Specify) Relative
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the Hospital or Attending Phi Inc. 4 hours after death. the Furneral Director: After thi mpletely filled in by the funeral Medical Certification: 7	2 Accident investigation 3 Sulcide 6 Could not be 28e Place of Injury		M 1	Yes 2 No			er or Rurel Route Number,
the Hospital or Attency hin 24 hours after deat the Funeral Director: mpletely filled in by the Medical Certifical	4 Homicida bullding, atc. (Sp	ecity)				wn, Stata)	
the Hospital hin 24 hours the Funeral upletely filled Aedical Co	29a. Certifiar (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.						
A S	29b. Signeture end title of certifier		29c. Licens	e number 533		29d. Date signed $3/1$	(Month, Day, Year) 5/99
10/	30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) PC 4	801 W	szonciv	Ave.	NN NDC
State Registrar	31. Date tiled (Month, Day, Year) MAR 1 6 1999	ignature	1	1 44		1 4 1 "	7.0016
MH 16 Rev 6/95		N. 19	packet			·	= 1 4



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middla, Last) Month 15 1999 12:10 AM March Μ. Mancuso Marion 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 1□M 2\ F Months Deys Oct 10, 1915 Pennsylvania 171-01-3259 10c. City, Town or Location 10d. Inside City Limits 10h County 1X Yes 2 No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6809 Decatur Pl. 20784 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 21 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decadent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 years 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middla, Last) Catherine Eichler Edward Lindenmuth 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Melanie Neidhammer - Daughter Hyattsville, MD 6809 Decatur Pl. 20a. Method of Disposition 20b. Plece of Disposition (Nama of camatary, crematory or other placa) 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/99 Hazelton, Pennsylvania Hazelton Cemetery 22. Name end Address of Facility 21. Signature of Funeral Servica Licenses Rendon/Hale Funeral Home 23a. Part1. Ent.: Ta disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or do not enter the mode of dying, such as cardiac or respiratory arrest, 20706 RESPIRATORY FAILURE Immediate Ceuse (Final disease or condition resulting in death) PNOVMONIA

/Medical

Department of important: If eny injury or page.

Physician

/Medical

Examiner

10e State

Director

Funeral

by

Completed

MD

11. Marital Status

Funeral

Director

"natural", or items 23s or adjest Examiner must be

the Medical

Pages 1 and 2 should be file mant of Haelth and Mental Hant: If item 27 is marked oth lury or other treumstic even

with the Maryland

72 hours aftar death

Baltimore, Maryland 21215-0020

Physician Examiner

physician and the bunal-transit

signed by the

irector, paga 2 s

To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funerel Director: Aftar this certifics completely filled in by the funarel director, I

Tha law requires that the death cartificate be axecuted

P.O. Box 68760.

Records,

Division of Vital

Examiner

Physician/Medicai

þ

Completed

Be

10

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest

Due to (or es a consequenca of):

WHY MYO CARPIAL INFARCTION

Due to (or es a consequence of):

ON ARY AATOMY DIPCASE

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INSUFFICIONCY

23b. Did tobacco use contribute to the cause of death? 1 Yes 2500 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 200 No

1 Tyes 2 No

25. Was case referred to medical 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specity)

Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Volo 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident

28c. Injury at Work?

28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier

3 Suicide

4 Homicide

15@Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and menner as stated.

2D Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and manner stated.

29b. Signature and title of opriving

6 Could not be determined

299 License number 928/95

29d. Dete signed (Month, Day, Year)

s of person who completed cause of deeth (Item 23a) (Type, Print)
A. GORAY. MD. 12164 CONTRAL AVE. MITCHELVILLE. MD.

State Registrar 31. Dete filed (Month, Pay, Yaar) MAR 1 6 1999



the company of the party of the company of the comp

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 1999 March 18, **Physician** REVA MALLOY 3:30 AM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (Steta or Foreign Country) **Funeral** Days Hours 1□ M 2□ F Yrs. Director 240-36-0203 Jan. 16, 1930 North Carolina Usual Residence of Dacedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mentel Hygiene.
7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, the Medical Example, must be notified at 1⊠Yes 2□No Maryland Prince George's Cheverly Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 6525 Landover Road, Apt #204 20785 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Black, White, atc. ☐ Yes 2 No 1 ☐ Never Married 2K Married 1 ☐ Yes 2 💢 No Specify: Specify: Black h 3 Widowed 4 Divorced Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Domestic Worker Private 7th permit. Pagas 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any injury or other traumatic event page. 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ben McCrimmon 0 Roxy McCrimmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Arthur Malloy/Husband 813 Maury Avenue, Oxon Hill, Maryland 20745 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 03/24 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, Maryland 22. Name end Address of Facility
J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licansee Nancie Ver 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fail in . List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final se DSUS lays disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner attanding physician and for use as the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): lon lais signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings evailable prior to completion of cause of death? bleen si 24a. Was an autopsy Completed this certificate has 1 Yes 2 No 1 Yas 2 No ial or Attending Physician: The safer death.

Signature of the service of the ser 25. Was casa rafarrad to medical Be 26. Place of Death (Check only ona) examiner? Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 □ ER/Outpatient 3 □ DOA 2 27. Mannar of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Cartifying Phyeician: To the best of my knowledga, daath occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature until title of certifier 29c. License number M Address of parson who complated causa of daath (Itam 23a) (Type, Print) rince

DHMH 16 Ray 6/95

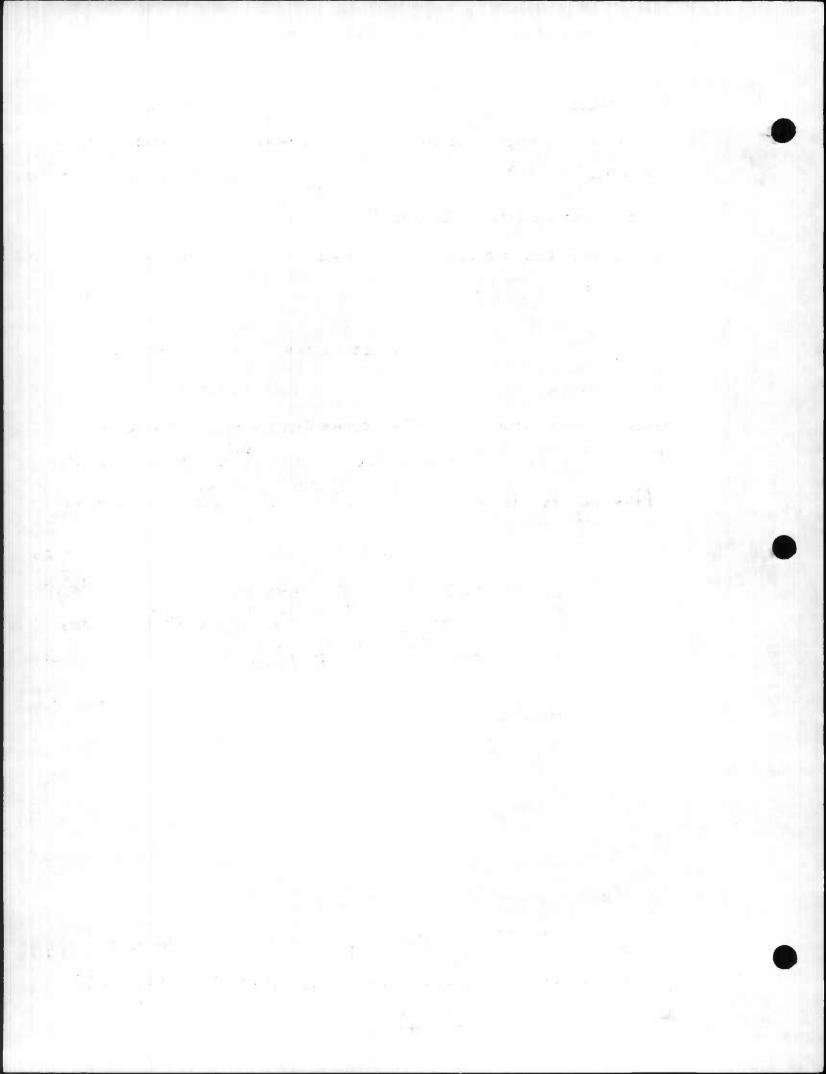
State

Registrar

31. Date filed (Month, Dey, Yeer)

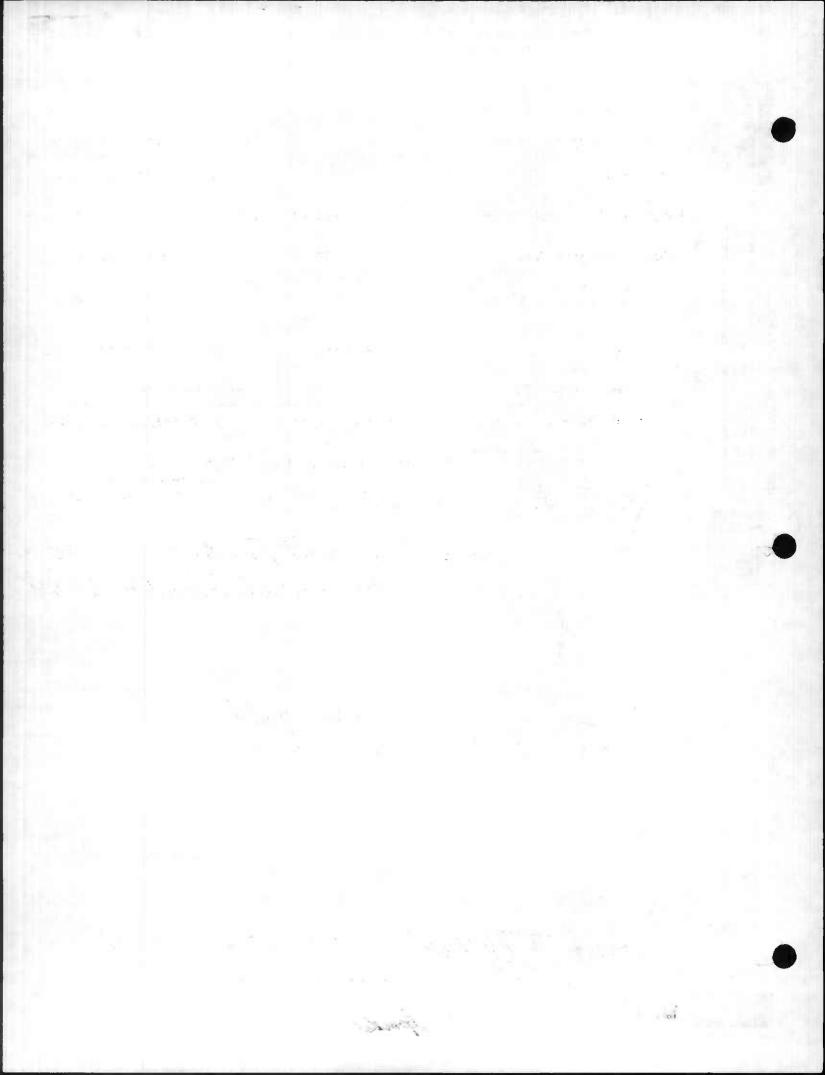
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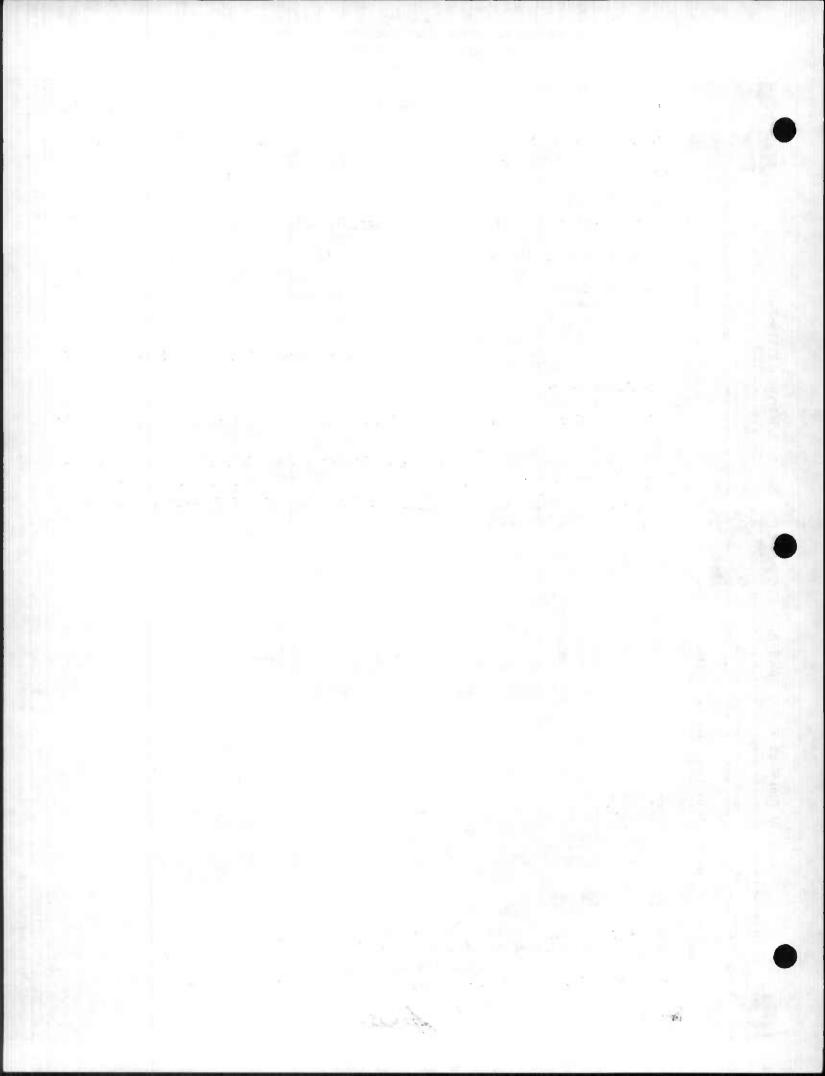
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

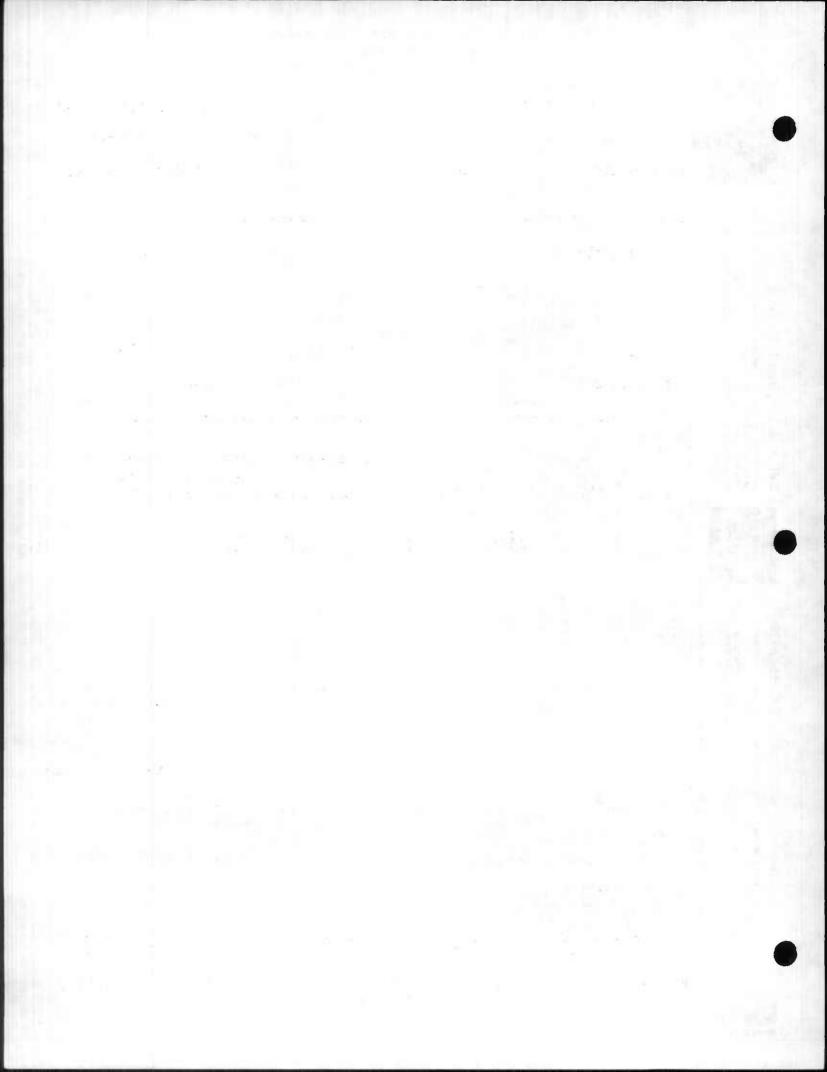
			C	ertificate of	Death	R	eg. No.		0914	
	1. Decedent's Name (First, Middle, L	ast)	111111111111111111111111111111111111111			2. Date of Deat Month	th Day	Year	3. Time of Death	
Physician	Lacy Langhorn	e Morris				March		1999	4:29PM	
/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, or L		4c. County		7.627111	
1	Prince George'	s Hospital			Chever1	V	Prin	ce Ge	orge's	
Funeral		Sex 7. Age	e (In yrs. last birthd	ay) If Under 1 Year	If Undar 24 Hrs.	8. Date of Birth			ace (State or Foreign	
Director	224-22-2216 Usual Residence of Decedent	10 M/ 20 F	7.5 Yrs	Months Days	Hours Min.	Sept 16			ginia	
Pud *=	10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits	
fire death with the Manylan ritems 23e or 28=4 show liner must be notified at Finneral Director	Maryland Prince	George's		Сар	itol Heig	hts			1 Yes 2 □ No	
or 2	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?	
th w	6314 Carrington	Court		2	0743		Unite	ed Sta	ates	
des des	11. Marital Status	12. Was Decedent I Armed Forces?	Evar in U,S. 1	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yas or No-	14. Rac	Race - American Indian, Black, White, etc.		
0 0 0			10	1□ Yes 2√√ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify		lack	
1 21215-002 ed within 72 hours ygiene ygiene neturel', r, tre Medical Ex.	15. Decadent's		16a. De	cedent's Usual Occup	nal Occupation 16b. K			usiness/Ind	lustry	
within 7 ene.	(Specify only highest g	rade completed) College (1-4or 5	lif	e. DO NOT use retire	dunng most of work d)	cing				
212 d within	12th	College (1-401 5	*/	Receive	r		Pri	ivate		
W 5. 0 ~ 1		st)			18. Mother's Nam	e (First, Middle, I	Maidan Sumam	ia)		
Vian build be Mental wrked o	James Morris	s, Sr.				Ruth Sa	unders			
	19a. Informent's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street	end Number or Rui			State, Zip	Code)	
M 2 Dd 2 Dd 2 Lth e Lth	Gail B. Holmes	- Daughte	r 63	314 Carrin	gton Ct	Capito1	Height	ts. M	D 20743	
s 1 end 2 f Health ttem 27 I	20a. Method of Disposition		20b. Place of Di	sposition (Name of		-	20c. Location -			
S = 2	1 Burial 2 □ Cremation 3			cremetory or other ple						
Baltimore semit. Peges 1- Separtment of He mportant: If iten my injury or oth	4 Donation 5 Other (Spec		Washing	gton Nation	6 E 1614					
Balti emit. Separtm mportar iny inju	21. Signature of Fluneral Service Lio	CI C		22. Nama and Addre		Stewart				
0	John I.	Heysarl	UI	4001 Beni	ning Rd.,	N.E. Wa	sh., D.	.C. 20	0019	
	23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arr	ast,		Approximate Interval Between	
Physician			,		0 -	7 1 7			Onset and Death	
C=/Medical	Immediate Ceuse (Finel disease or condition resulting In death) a. Congettive Heart Failure b. A Cuttl My Olar dial vifar (tion)									
Examiner	resulting In death)	a	Due to (or es e con	sequence of):	-	4	. 1		1	
		AC	-00	MUDE	- noine	Pil	2 Silia	- 1	Quo 11el	
owecuted in and iel-trensit	Sequentially list conditions	b	Due to (or es a con	sequence of):	vicu i	Nopa	ercuo		Jra wife	
Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury									
68760, tificate be executed g physicien and es the buriel-trensit	that initiated events	C	Due to (or as a con	sequence of):						
W =	resulting in death) Last			334231134 317						
		d								
P.O. Box lat the death certification of the ettending etached for use ethors.	Dad II Other significant can distance		A A		t- D t	Ont Dida			Abo source of death 0	
tribe de by the cached	Part II. Other significant conditions	contributing to death bu		^					tha cause of death?	
	phunge.	a - Ceri	Varel	rescute	raccid	el III	es 2 No	3 Prob	bably 4 Unknown	
0 8 Pg 0				stus .	0	24a. Was a	vanautonsv	24b. Wa	are autopsy findings	
The lew require sate hes been si page 2 should	(gargerer	v - Amost	- DOCO	, butters	ullons	perfor	med?	ava	ailable prior to mpletion of cause death?	
The lew ate hes b page 2 s		100	7	0				of c	death?	
The I						1 🗆 Y	es 2 No	1	Yes 2□ No	
Vital Prician: The certificate rector, pag	25. Wes case referred to medical examiner?				26. Plece of Dea	th (Check only or	ne)			
Of Vital Physician: The centificate and director, per TO Be Co.	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpe	tient 3 DOA Ot	her: 4 \substitute Nursing He	ome 5 Resid	ence 6 □Oth	er (Specify)	
Ming Ph After th funeral	27. Menner of Death 1 ☑Neturel 5 ☐ Pending	28e. Date of Inju-	y Year) 28b. Tim		ry at	28d. Describe h	ow injury occur	red		
ndin ath. r: Aff	2 ☐ Accident investigati	on	.,_		Yes 2□No					
Division of the or Attending P is effect death. The or Attending P is offector: After the or offector: After the or offector: After the or offector: After the or offector: After the or offector: After the or offector: After the or offector: After the offector: After the or offector: After the or offector: After the or offector: After the or offertive the or of	3 ☐ Suicide 6 ☐ Could not determine	a 200. Place of Inti	ry - At home, tarm,	street, factory, office		28f. Location (S		per or Rura	l Route Number,	
din din	4 LI Homicide	building, etc	:. (Зреспу)			City or Tow	n, State)			
Hospi 14 hou Funer tely fill	29a. Certifier (Check only (Ch									
	29b. Signature and titla of certifier	and manner sta	100.	29c. Licens	se number		29d. Date signe	d (Month	Day Yearl	
2108	and the or corplier	1 10/1	du	1	OLIA -	7/1	A. Date signe	10/	10100	
17	Sam	1 (11/1	M		7721	7	21	18	17	
10/	30. Name and address of person who									
	Sam Tellawi, MD - 7700 Old Branch Ave., Clinton, MD 20735									
State	31. Date filed (Month, Day, Yeer)	32. Registre	er's Signature							



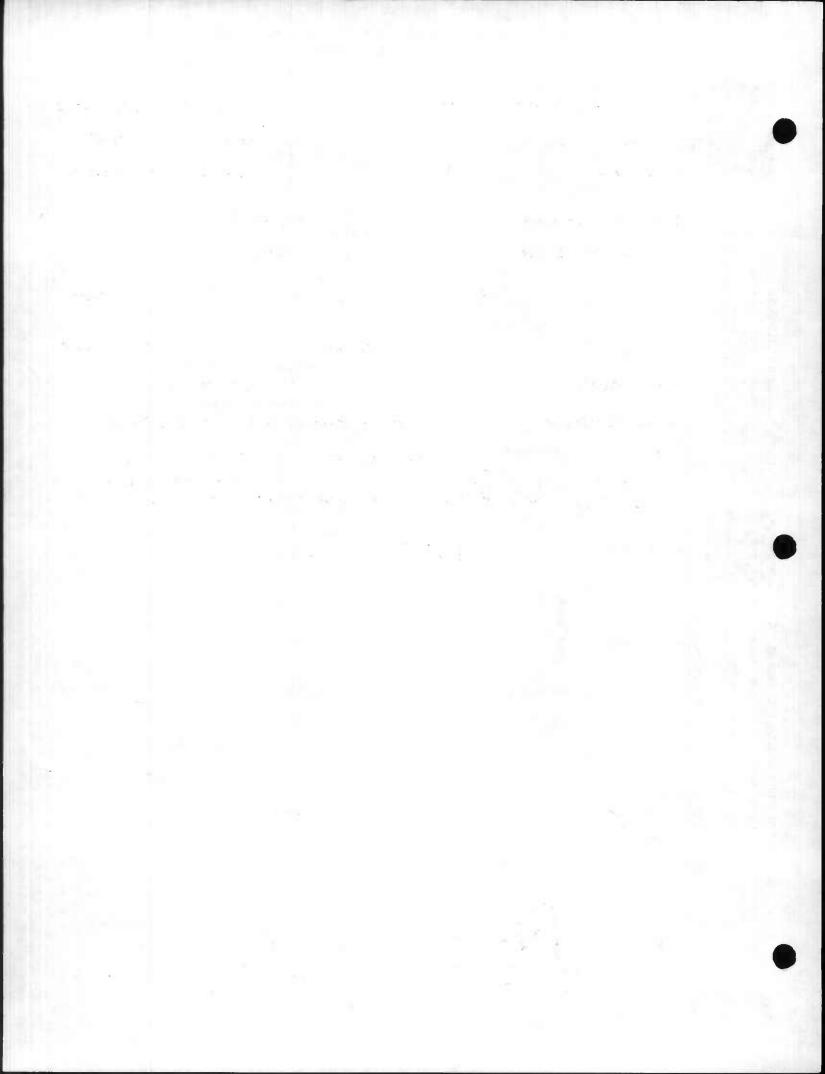


State of Maryland / Department of Health and Mental Hygiene

				(Certifica	ate of	Death		Reg. No.	1	U.946
Physicia		1. Decedent's Name (First, Middle, I						2. Date of De Month	Day	Year	3. Time of Deeth
/Medic	_		Ruth Monro	e				March		999	6:00 am
Examine	er	4a Facility Name (If not institution, g 8208 Ridgelea C					4b. City, Town, Frede	or Location of Deet	,	of Death reder	rick
-	Н			yrs. last birth	If Und	der 1 Yeer	If Under 24				
Funeral Director		220-32-3258 Usual Residence of Decedent	1□M 2\xF 87		rs. Month	Deys			7, 1911	Inc	lace (State or Foreign try) liana
dand was	-	10a. State 10b. County	10c	. City, Town	or Location					1	0d. Inside City Limits
Mary	to	Maryland Frede	rick				Freder	rick			1 ☐ Yes 3 No
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Etant or must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 8208 Ridgelea C	t		10f. 2	Zip Code	217	702	10g. Citizen of W		ntry?
death	ner	11. Merital Stetus	12. Was Decedent Ever Armed Forces?	in U,S.	13. Was Dec	cedent of h	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	o- 14. Race	- Americ	an Indien,
Z1Z15-UUZU d within 72 hours aftar giena. r than "naturel", or its the Medical Examire	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced			100000	2 No	Specify:	derio Fricari, etc.,	Specify:		nite
5-0 72 ho	eted	15. Decedent's (Specify only highest of	Education	1	Decedent's Us	work done	during most of	working	16b. Kind of Bu	siness/Inc	dustry
ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	d)	•	Ch	nurch	
Aygied w	S	11. Father's Neme (First, Middle, La			O.	rgani		Name (First, Middle			
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic svent.	Be	Henry C. Cook	51)					Ethel Glo		"	
M M M M	4	19a. Informant's Name/Relationship	(Type Print)	19b	Mailing Addre	ess (Street	t	r Rural Route Numb		Stete. Zip	Code)
Ma ith an ith an ith an ith an ith an		Miriam Raedy, d						rederick			
re, M s 1 and 2 f Haalth flam 27 i	1	20a. Method of Disposition		Ob. Place of I	Disposition (A	Vame of		Date	20c. Location -		own, Stete
Pages nent of I int: If he		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Carmel			3/20	Parkt	con,	MD
Baltimore, permit. Pages 1 at Department of Hae Important: if item; any injury or othe	Ì	21. Signature of Funeral Service Lic			22. Name	and Addre	ess of Facility	Eline l	Funeral H	Home	
	_	service va	coun	~ D				St, Hamps) 210	
Share Select		23a. Part1. Enter the disease, or co shock, or heert feilure. List on	ly one cause on each line.	1 /	of enter file in	s and	ng, such as cal	diac of respiratory c	111031,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final	Motal	FETR	2	bne	tra	CA			Dure 9 Lux
Examiner		disease or condition resulting in death)			9	911 1000					
TAXABLE PARTY.	ner				1						
68760, tiflicate be axecuted g physician and as the bunal-transit	edical Examiner	Sequentially list conditions,									
e axe ian a	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760, flicate be av physician is the buria	dica	that Initiated events resulting in deeth) Last	C. Due 1	to (or as a co	onsequence o	of):					
O 0			d							i	
BOX eath cert attandin for use	lan									İ	
dS, P.O. BOX ires that the death cer signed by the attendir d be detached for use	Physician/M	Part II. Other significant conditions	contributing to death but not	t resulting in	the underlyin	g cause gi	ven in Part I.				the cause of death?
that the detail	P							1	Yes 2 No	3 Pro	bably 4 ☐ Unknown
I HECOrds, P.O. BOX The law requires that the death cer ate has been signed by the attendir page 2 should be deteched for use	Completed by								s en autopsy ormed?	00	ere autopsy findings allable prior to impletion of cause
Hec e law has l	mp								/		deeth?
in The Hicata	ပ္	DS. Was soon referred to medical					00.51		Yes 2 No	1 L	Yes 2110
VISION Of VITA Attending Physician: In death. ector: After this certific by the funerel director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	nationt 2	DOA Ot	hor:	Deeth (Check only		ar /Snecil	(v)
Phy erel d	n: To	27. Manper of Death	28a. Date of Injury (Month, Day Yea		me of	28c. Inju	4 🗀 140131		how injury occurr		<i>y</i> /
odling ith.	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		ar) In	jury M		rk≀]Yes 2□No				
المراجع المراج	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		28f. Location City or To	(Street and Number own, State)	er or Rura	al Route Number,				
To the Hospital within 24 hours To the Funeral completaly filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, dea and manner stated.							placa, and due to the occurred at the time	ceuse(s) and ma , date and pieca, a	nner as s	stated. the cause(s)
ithin the the	Mec	29b. Signature and title of certifier 29c. License number							29d. Date signed	(Month.	Day, Year)
F 3 F 8		296. Signature and title of certifier Source Auto Mo						8	3-17		9
	-	30. Name and address of person wh	no completed cause of death	(Item 23a) (1		- ,-,		<i></i>	- 11		1
		Flavin Kriller	mp 224 11	hash.	nah	allo	dela	Whatmin	solor m	D =	01157
Stat	te	31. Date filed (Month, Dey, Year)	32. Registrar's S	Signature	3	,	0.10	WWW.TITT	M. I	·V 0	
Registra	_	MAR 1 8 199	39 penera	1	· de	ack	/				

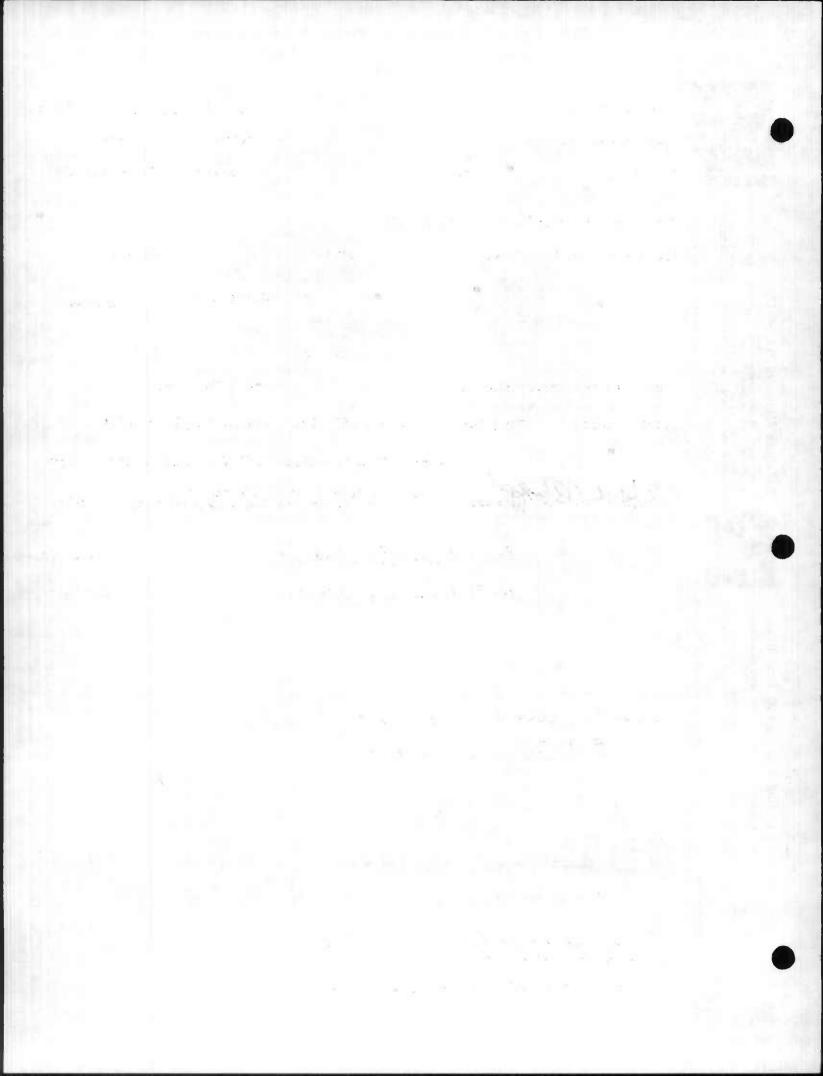


Director Usual Peacledine of Decedent 10e. Clay. Town or Location 10e. Clay. Town or Loc	ace (State or Found) y Land od. Inside City Lit 1 Yes 2 x try? an Indian, bitc. nite
Mell'all Mayson Martin Meld'all Examiner Merch 17, 1999 46	ace (State or Form) / Land Od. Inside City Li 1 Yes 2 7 iny? an Indian, etc. nite lustry
Second Security Name Second Se	ace (State or Found) y Land od. Inside City Lit 1 Yes 2 x try? an Indian, bitc. nite
Social Security Number 6.5 ex. Social Securit	ace (State or Found) y Land od. Inside City Lit 1 Yes 2 x try? an Indian, bitc. nite
Sept 18,1905 Mary Sept 18,1905 Mary	7 Land od. Inside City Li 1□ Yes 2√x any? an Indian, etc. nite lustry
Usual Residence of Decederal 10e. State 10e. County 10e. State 10e. County 10e. State 10e. County 10e. State 10e. County 10e. State 10e. County 10e. State 10e. County 10e. State 10e. County 11e. Maryland Baltimore 11e. Status 11. Maryland Saltimore 11e. Was Decedent of Hispanic Ordin? (Spacify Yes or No- 11 Nertial Status 11. Nertial Status 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 12. Vess Guery 13. Nesterial Relationship (Type, Print) 14. Racce - America 11. Nertial Status 12. Nesterial Relationship (Type, Print) 14. Racce - America 12. Nesterial Relationship (Type, Print) 15. Locatedent's Usual Cocupation (Specify) orth highest grade completed) 16. Nesterial Relationship (Type, Print) 17. Fether's Name (First, Middle, Last) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 19. Marrige O. Armacost 19. Marrige O. Armacost 19. Nesterial Relationship (Type, Print) 19. Informant's NamePalationship (Type, Print) 19. Informant	od. Inside City Li 1 Yes 2 k try? an Indian, etc. nite
Elementary/Secondary (0-12) Believe that for the state of the state o	1□Yes 2½ iny? an Indian, olc. nite
Elementary/Secondary (0-12) College (1-4or 5+) Foreman Construct	an Indian, etc. nite
Elementary/Secondary (0-12) College (1-4or 5+) Foreman	an Indian, aic. nite Justry
Elementary/Secondary (0-12) College (1-4or 5+) Foreman	nite Justry
15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Specify only highest grade completed) 16. Decedent's Usual Occupation (Specify only highest grade completed) 16. Kind of Business/Ind. (Give kind of work done during most of working life. DO NOT use retired) Foreman 17. Fether's Name (First, Middle, Last) Albert Martin 18. Mother's Name (First, Middle, Meiden Surmeme) Albert Martin 19a. Informant's Name(Relationship (Type, Print) Ronald Martin, son 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip of Cometery, cremetory or other place) 10c Description 10c Descriptio	nite Justry
15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade grade grade grade grade grade grade grade grade grade grade grade grade grade grad	
Sequentially list conditions, resulting in death) Last Sequentially list conditions, resulting in death)	
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58 5	
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old	deeth?
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25. Was case referred to medical examiner? Hospital:	
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify	1)
5 1 □ Naturel 5 □ Pending (Month, Day Year) Injury Work?	
2 Accident investigation 3 Suicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Specify) 288. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural City or Town, Stete)	
28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)	I Bouda Number
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29c. License number 29c. License number 29d. Date signed (Month, L	tated.
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	lated. the cause(s)
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)	lated. the cause(s)
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State State Registrar MAR 1 8 1999 Security Signature State Registrar MAR 1 8 1999	lated. the cause(s)

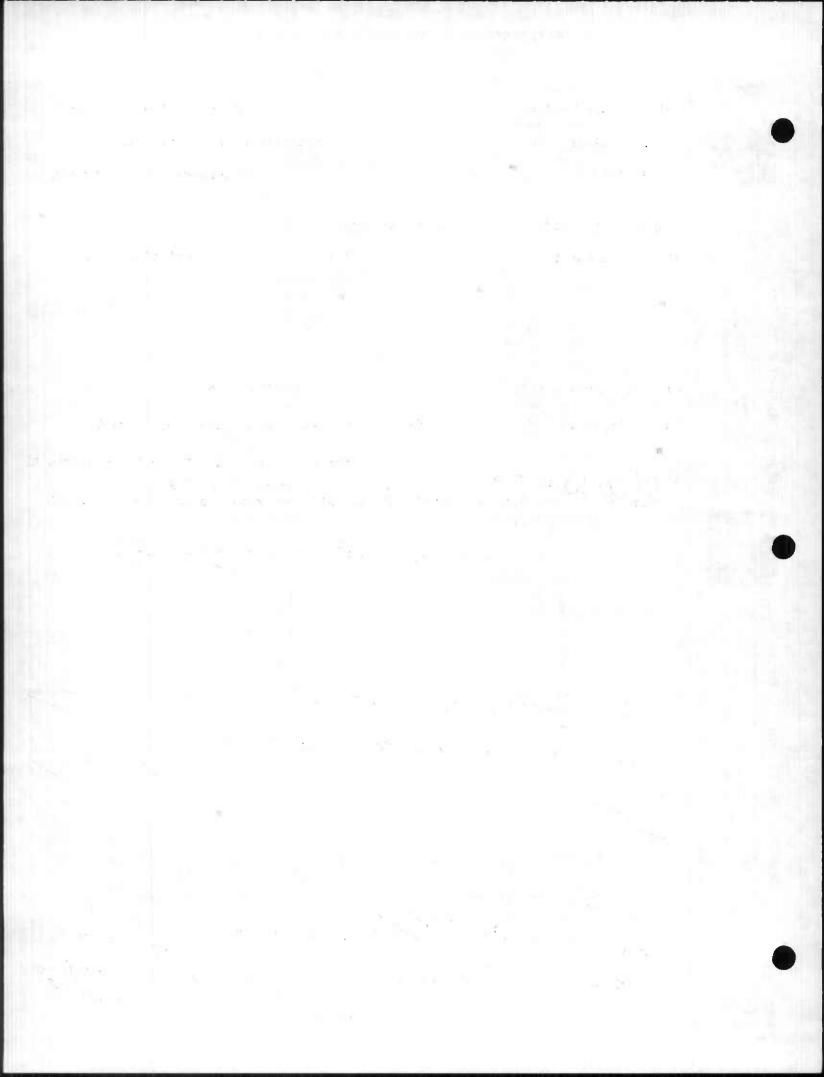


State of Maryland / Department of Health and Mental Hygiene

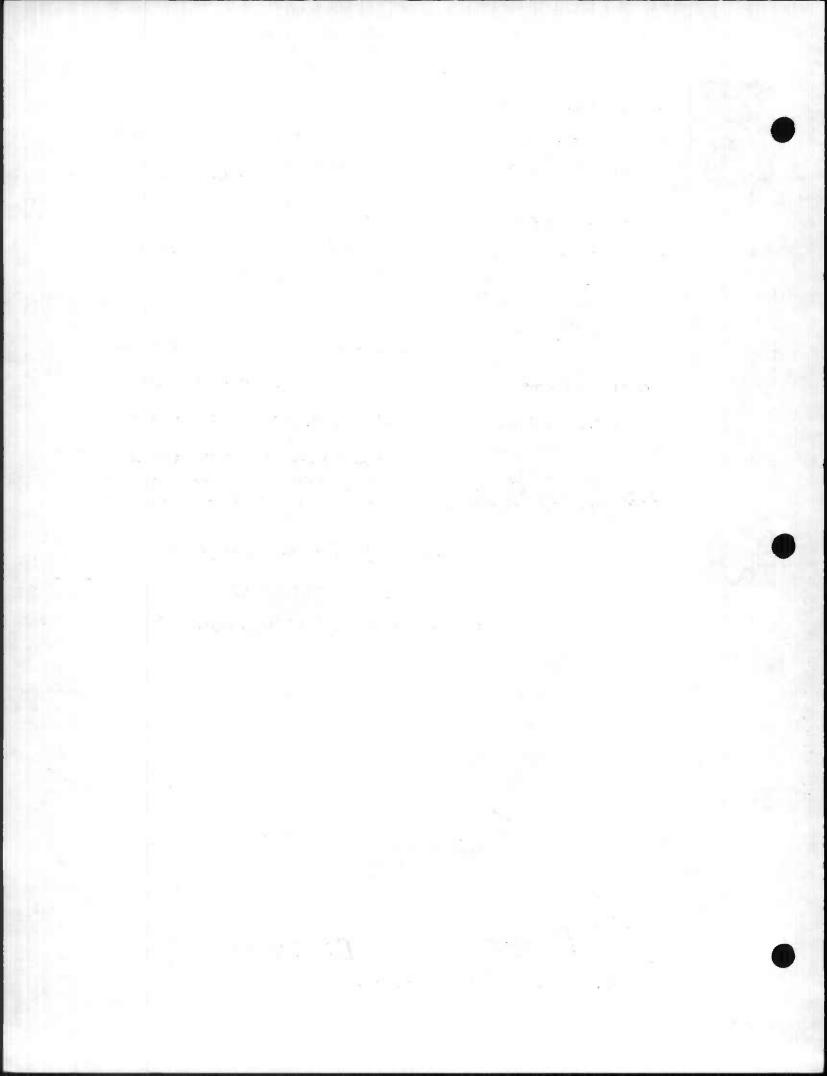
	1. Decedent's Name (First, Middle, L	Last)		76				Data of Deat			3. Tima of Death
Physician	Rumelda Monroy							Month arch	Day 13, 19	Yaar	1:53p.m.
/Medical Examiner	4a Facility Nama (If not institution, g	giva straat and num	ber)			4b. City, Town					1.55p.m.
LAGIMITICI	St. Mary's Hospi	tal					nardt			Mary'	S
Funeral Director	067-84-6131	Sex 1 M 2 F	7. Age (In yrs. Ia 65		If Under 1 Yea Months Days	If Undar 24 Hours	Min. Feb	Date of Birth Month, Day, ruary	7,1934	9. Birthple Count Guat	ace (State or Foreign dry) emala
how	Usual Residence of Decedent 10a. Stata 10b. County		10c. City,	Town or Loca	ation					10	Od. inside City Limits
gard attitude	Maryland St. Ma	ry's	Grea	at Mil	ls						1 ☐ Yes 2 € No
or items 23a or 28a-f show imber must be notified at / Funeral Director	10e. Street and Number 20228 Point Look	cout Road			10f. Zip Code 2063	4		1	Og. Citizen of V		try?
iner mat iner mat Funeral	11. Marital Status	12. Was Deced	dant Ever in U,S	. 13. Wa	as Decedent of Yas, specify Cu	Hispanic Origi	n? (Specify Puerto Rica	Yas or No-	14. Rac	a - America ck, White, e	an Indian,
D E.	1 Never Marriad 2 Married 3 Widowed 4 Divorced		2 N o		Yes 2□ No						panic
dicat Ex	15. Decedent's (Specify only highest of	Education		16a. Decede	nt's Usual Occuind of work done O NOT use retir	pation	of working		16b. Kind of B	usiness/Ind	ustry
A the Medical	Elementery/Secondary (0-12)	College (1-	4or 5+)				J. WORKING		N/A		
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n a m	Jose Dolo Res Mo		cia					Coro		110)	
marks	19a. Informant's Name/Ralationship			19b. Mailing	Address (Stree	et and Number	or Rural Ro	oute Number	r, City or Town,	Stete, Zip	Code)
27 ts	Ericka Monroy,	Daugh	ter		ox 587,						
E H S	20a. Method of Disposition		20b. Pla		tion (Name of atory or other pi				20c. Location -		wn, Stata
# 50 H	1 ☐ Burial 2 ■Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		REG		tan Cre		3/17	/99	Alexand	lria.	Virginia
/ injury	21. Signature of Funeral Service Lic	erfsee . /		-	Name and Add				75.00		
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			State of	Marylan		artment ertificate			nd Mental H	ygiene Reg. No.	99	1091	9
	147	1. Decedent'a Name (First, Middle, Las	t)						2. Data of I	Death Day	Year	3. Time of	Death
	Physician /Medical	Nellie Essie McGla	ade						March		999	3:22	PM
	Examiner	4a Facility Name (If not Institution, give		ber)					vn, or Location of De		County of Death		
		45918 Patuxent La			4 4 4 4 4) If Under	-	exing	ton Park		. Mary		
	Funeral Director	5. Social Sacurity Number 6. Se 10 10 10 10 10 10 10 10 10 10 10 10 10	M 2 F	7. Age (In yrs.	ast birthday Yrs.	Months	Days	Hours	Min. 8. Date of I (Month,	Day, Year)	9. Birth Cou	place (State or intry) irginia	Foreign
Ц		Usual Residence of Decedent		- / /					deptem	JEI 4,	192µ V.	riginia	
	show thow	10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City	
	urs efter deeth with the Mei alf, or items 23s or 28s4's as where must be notified by Funeral Director	Maryland St. Mary	y's	Lex	ringto	n Parl						1 🗆 Yas	2 II No
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	s 23	45918 Patuxent Lat	ne 12. Was Deced	lent Ever in U	S 13		2065		in? (Specify Yas or		ed Stat		
	r then	1 Never Married 2 Married	Armad Ford	ces?	3. 10.			n, Mexican	in? (Specify Yas or Puarto Rican, etc.)		Black, White		
020	al', o	3 ■ Wildowed 4 □ Divorced	If Yes, Give Year or Da			1□ Yas 2	2■ No	Specify:			Specify:	Thite	
21215-0020	be filed within 72 hours efter deeth with the Meryland lel Hygiene. d other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	ucation de completed)		16a. Dece	edent's Usua e kind of wor DO NOT us	l Occupi	ation Juring most	of working	16b. Kir	nd of Business/Ir	ndustry	
121	Mple Mple	Elementary/Secondery (0-12)	College (1-	4or 5+))					
	Hygie ther ther ther the Co	12 17. Father's Name (First, Middle, Last)				Homema	aker	18. Mothe	r's Name (First, Midd	fle, Maiden	N/A Sumame)		
lan	Mentel Mentel arked of arked o	William Andrew Wi	ndfield						Essie The				
Maryland	should mer marke umatic	19a. Informant's Name/Relationship (T	ype, Print)		19b. Meil	ling Address			r or Rural Route Nur		r Town, State, Z.	ip Code)	
	end 2 ealth e	Lori Fitzgerald						et, C	harlottes	ville,	VA 229	902	
ore	of He	20a. Method of Disposition 1 ■ Bunal 2 □ Cramation 3 □ I	Ramoval from S		lace of Disp emetery, cre	osition (Nameratory or o	ne of ther plac	e)	Data	20c. Lo	cation - City or T	Town, State	
altimore,	ment of lary or o	4 □ Donation 5 □ Other (Specify,)				_		dens 3/17			n Park	, MD
Bai	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryler Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any fujury or other treumstic event, the Madral Examinar must be notified an once. To Be Completed by Funeral Director	21 Signature of Funeral San Sa Licens	W/						eral Home			m 0065	0
H		23a. Part1. Entar the disaese, or comp shock, or heart failure. List only o	nkenshi						d Road, Lo		itown, M	Approximate	
	Physician	shock, or heart failure. List only o	ne cause <i>on</i> ea	ch line.								Onset and D	veen leath
	/Medical	Immediate Cause (Final disease or condition	of 14	nes	long	ger							
	Examiner	resulting in death)	u	Due to (o	r as e conse	equence of):			0			0	
	exacuted an and riel-transit.	_	b										
ć	be executed sician and buriel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying		Due to (o	r as a conse	equence of):							
1200	ysicie ysicie le bu	that initiated events	C	Dua to (or	as a conse	quence of):							
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Вох	tendi or use		d										
0	requires that the deeth certificate been signed by the ettending physinould be deteched for use as the etted by Physician/Medic	Part II. Other significant conditions on				undanying	Ture diy	nn in Part I.	23b. D	ld tobacco	use contribute	to the cause o	death?
0.	ed by detect	1 200	our	alle	42				1	☐ Yes 2	□ No 3□ Pr	obably 4 🗂	Unknown
Records,	w requires that should be det should be det	HTW				0 4	0			as an autop		Vera autopsy fi	
00	The law require sate has been signed as been signed.	Hud	ا مست	2/	he	o u	100	300	p∈	rformed?	C	vailable prior to completion of ca of death?	ause
	The law ate has beage 2 s	/							11	☐Yes 2[ZNo 1	□ Yes 22	No
Viital	sician: The law certificate has birector, page 2 s	25. Was cese referred to medical examiner?						26. Plece	of Death (Check on	ly one)			
of <	this ceral direction To 1	1 ☐ Yes 2 ☑ No	Hospitat: 1 🔲 In	patient 2	ER/Outpatle			4 LI NU	rsing Home 5			city)	
ono	tal or Attending Physician: stated death. al Director: Atter this certific led in by the funeral director. Certification: To Be (27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigation	28a. Dete of (Month)	Injury , Day Year)	28b. Time of Injury	of 2	8c. tnjun Worl	yat k? Yes 2 □!	28d. Describ	e how Injur	y occurred		
Division	Atten or dea octor. by the	3 Suicide 6 Could not be determined	200. Flace	of Injury - At he		treet, factory	, office		28f. Location	(Street an	d Number or Ru	ral Route Numi	ber,
Ö	al Dir	4 Notificide	bullain	g, etc. (Specif	r)				City Gr	Own, State	<u></u>		
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: Atten this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com			sts of examinat					d place, and due to the time of the control of the time.)
	outhin outhough	29b. Signatura and title of certifiar	n N	7	6.0	290	Licens	pumber	ncc.	29d. Dat	e signed (Month	Say Year)	
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		30. Name and address of person who	ompleted carge	of death men	123a) (Type	, P/int)	m	0	2010	0	Die	-Net	de
		1/19000	- ///	. / 6	ceev	ne	/ /		10200) /	1/00	offor	9
	State Registrar	31. Date filed (Month Aar Year) 6 19	999 32. Re	gistrar's Stgna	ture	9. 4	oou	h			///		



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		Security Number	6. Se	×]м 2Ы́ F	7. Age (In yrs. les 71	Yrs.	If Under 1	Year Deys	If Under: Hours	Min.	8. Date of Bir (Month, De August	y, Year) 18,1		9. Birthp Coun Ma	lace (State or Fo iry) ryland
or	Usuel Res 10a. State Maryl		nty Mar	v¹e	10c. City, 1		cation Point							1	0d. Inside City Li
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by Funeral		ever Merried 2 Milli Fidowed 4 Divorce		Armed For 1 Test of Yes, Given To D	rces? No	- 1	1 Yes, specify	Cube	Specify:	, Puerto	Rican, etc.)			Whita,	
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To Be		rs Neme (First, Middl hn Melvin		nes							e (First, Middle, e Genev				
		ment's Name/Reletio									Point,			tata, Zip	Code)
	20e. Meth	od of Disposition Buriel 2 Cremetion Conetion 5 Other	n 3 □ F	Removel from	20b. Pled	atary, cren	sition (Neme netory or othe s Catho	er pled		erv	Dete 3/30/99				own, Stete aryland
by Physician/Medical Examiner		tura of Funaral Service			0	Mã	Name and	Addre	ss of Facilit	iner	Funera rdtown,	1 Hon	ne,	P.A.)650
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Physicia /Medic Examin

Funeral Director

permit. Papes 1 and 2 abould be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiens. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at odds.

Physician /Medical Examiner

To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

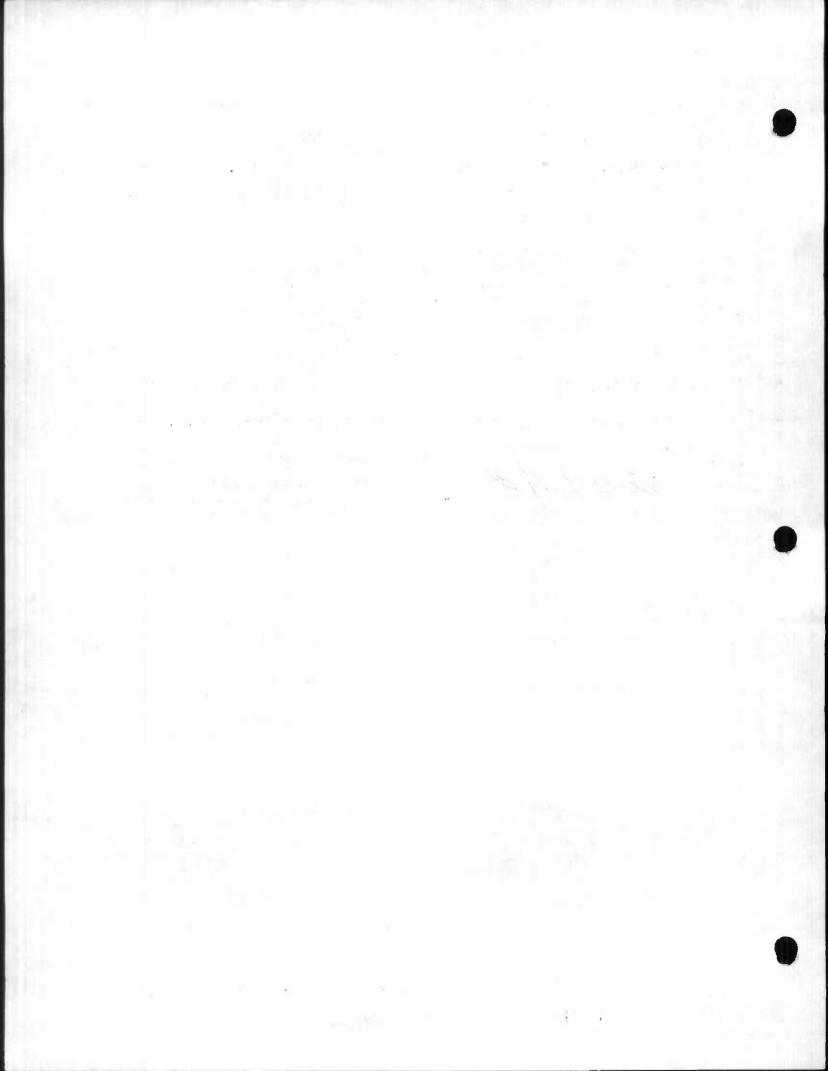
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4a Facility Nama (If not ins	titution, give	street and n	ımber)					4b. City, To	wn, or L	MARCH ocation of Dea		lc. County		08:47	_AM
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10					Wat	erma	n				S	eafoc	d In	dustry	
17. Father's Name (First, A	liodla, Last)							18. Moth	er's Nan	ne (First, Middl	le, Maid	en Sumam	a)		
Thomas Lero	y Madd	lox						Edi	th Y	vonne (Coat	es			
19a. Informant's Name/Re	lationship (7	ype, Print)		19b.	Mailing	Address	(Street	and Numb	er or Ru	ral Routa Num	ber, City	or Town,	State, Zip	Code)	
Edith Maddo	v	Mot	her	PO	R	ON 3	02	Dino	, Do	int, Ma	7	and 2	0674		
Edward N 23a. Part1. Enter the dises shock, or heart failure			, Jr. I caused tha de aach line.			229	55 1	Holly	boow	ral Hor Road, or raspiratory	Leo		own,	MD 20 Approximata Interval Betwonset and D	reen
Immediate Cause (Final disease or condition resulting in death)		a	Due to	Wau (or as a co	nd	once of)	1	Che	251			4	1 1 1		
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Sequentially list conditions if any, leading to immediat			Due to	(or as a co	onseque								i i		
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State Registrar

31. Date filed (Month, Day, Year) MAR 3 1 1999

David

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Q Q 1 Q 2 2

						Ce	rtificate	of I	Death			Reg. I	No.			
Physician	ו	Decedent's Nema (Fire Arnold Wil		Moomau							2. Dete of De Month MARCH	1	Day 1999	Yaar		me of Deeth
/Medica · Examine	4.0	Sacred Hea	III		m <i>ber)</i>		-	4		wn, or Loc perla	cation of Deet	th	4c. County			
Funeral Director		Sociel Security Number 217–14–4086	5 3	ex M 2□ F	7. Age (In yrs	last birthday Yrs.	Months	Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De June 2	rth By, Yea	1923			te te or Foreign rginia
Maryland a-f show filed at	10		. County Mineral			ity, Town or L Ledmont								10		de City Llmits
sth with the Mai		0e. Street end Number 51 Jones S	St.		•			750				Uni	Citizen of W Lted S		-	
72 hours efter deeth with the Maryland "natural", or frems 23s or 28s-f show ad cal Examiner must be notified at	2	1. Marital Status **Naver Married 3 **D Widowed 4 **D I		12. Was Dec Armad Fo 1 ☐ Yes If Yes, Gi Yaer or D	2⊠N o ve	J,S. 13.	Was Decade If Yas, speci 1 ☐ Yes 2		ispanic Orl n, Mexican Specify:	gin? (Spe , Puerto f	cify Yas or No Rican, etc.)	0-		a - Amarica k, Whita, e Wh:		
filed within 72 ho Hygiene. other than "natur	ompieted	15. I (Specify on Elementery/Secondary Unknown	, , ,	ucation da completed) College (1-4or 5+)	(Give	edent's Usuel e kind of work DO NOT use Mine	done o	during mos	t of workin	ng		Kind of Bu			
be fill H and H an	0 1	7. Fathar's Nama (First, George W.		l							(First, Middle lay Dav	, Maio	Maiden Sumame)			
12 sh h end ris m traum	1	9e. Informent's Neme/F	ey / Si			32	26 S. 1	Mair			ser, W	IV.	26726	5		
permit. Pages 1 and Department of Healt Important: If item 21 any Injury or other 1 pnce.		0e. Method of Disposition 1 Buriel 2 □ Cra 4 □ Donetion 5 □	amation 3 D Other (Specify	")	State	Plece of Disp cemetery, cre COMAC N	Memoria	al C	Garden		Dete /12/99		Location -	WV	wn, Ste	ete .
permit. Pag Department Important: I any Injury o	2	1. Signatura of Funeral	Service Lican	see he L	Posl		2. Neme end						nurch rnport	, MD		1562
Physician /Medical Examiner	lr d	Boal Funeral Home Westernport, N 23a. Part1. Entar tha disaase, or complications that causad the daath. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. Immadiate Cause (Final disease or condition resulting in death) e. RESPIRATORY FAILURE											Onsat	ximata el Between and Death		
executed n and ial-transit		sequentially list condition	ns C	ьС	ARCINON	(or es e conse IA OF L (or es e conse	UNG								unl	cnown
certificate be executed ding physician and use as the burial-transit		sequentially list condition eny, leeding to immediause. Enter Underlying Seuse (Disease or Injury nat initiated events esulting in deeth) Last	iate	сМ	ETASTAS		MEDIAS	STER	NUM						1 т	nonth
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S 500 L	CORONARY ARTERY DISEASE										24a. Was	s en ei		ava	ilabla	opsy findings prior to on of cause
Physician: The lattice that this certificate harried director, page	0 2	5. Wes case referred to exeminer?	o medical							of Death	1 ☐		2 X No	1□] Yes	2 No
hy sign	- -	1 ☐ Yes 2 🗶 No				ER/Outpetie		_	4 LINU		me 5□Res				1)	
		2 Accident	Pending investigation		th, Day Year)	28b. Time Injury	М		y et k? Yes 2□	No	28d. Describe				l Route	Number.
Hospital or Attending 4 hours efter death. Funeral Director: Attel taly filled in by the fune										d plece, e	City or To	ceuse	e(s) end me	enner es st	ated.	

State Registrar

30. Name and address of person and completes clause of death (tiem 23s) (Type, Print)



29c. License number

D15463

29d. Date signad (Month, Day, Year)

MARCH 12 1999

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X OF BUILDING

open or the right

State of Maryland / Department of Health and Mental Hygiene

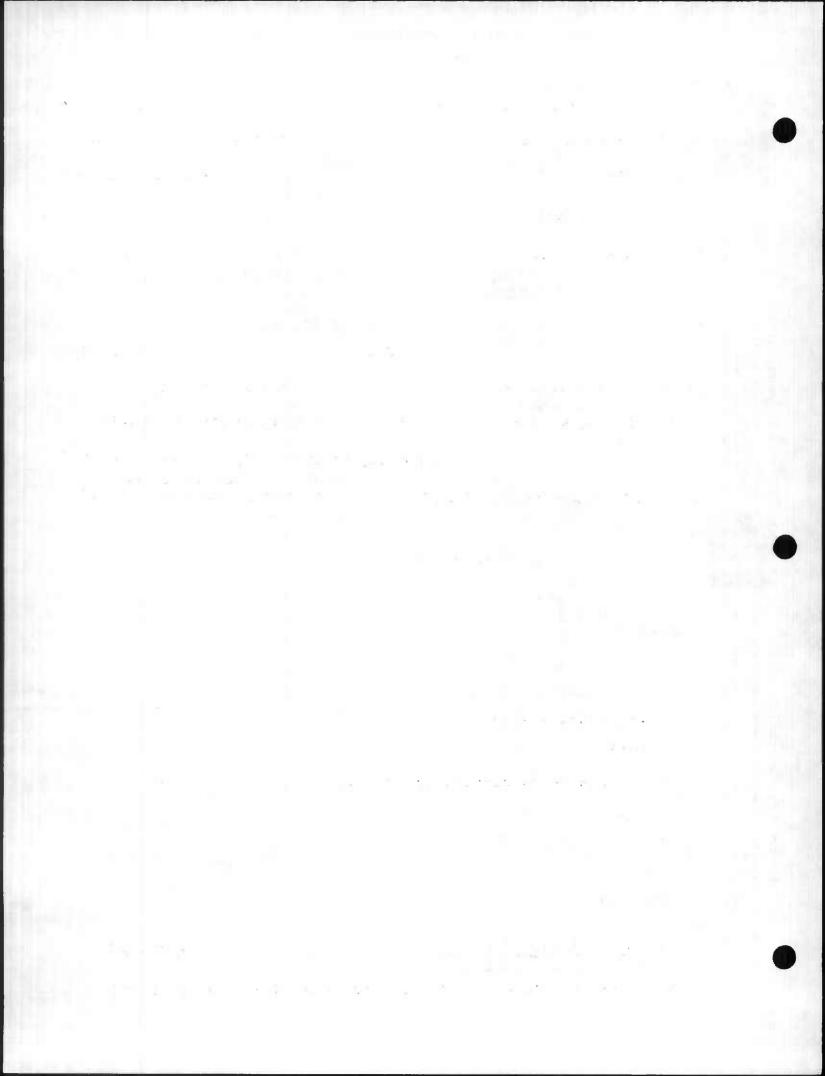
		Decedent's Name (First, Middle, Las.	1	С	ertificate of	Death	2. Dete of Deat	eg. No.	4 4 0	3. Time of Death	
Physic	ian			N. T. T.			Month	Day	Year		
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Exami	ner										
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Funeral Director			X /.A	76 Yrs.	Months Days		8. Date of Birth (Month, Day, July 1,	Year)	9. Birthplace Country Russi	e (State or Foraign a)	
the Maryland 28a-f show		10a. State 10b. County		10c. City, Town or	Location				10d	. Inside City Limits	
Ne W	5	Maryland Montgome:	ry	Silver S	pring					1 XYes 2 No	
death with the Maryland ms 23a or 28a-f show mast be notified at	al Dire	10e. Street and Number 10921 Inwood Avent	ue, Apt.	428	10f. Zip Code 20902	2	1	0g. Citizen of V	What Country	?	
P 2 2	y Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	3. Was Decedent of lif Yes, specify Cub	Hispenic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White, etc).	
72 hours naturel',	N N	15. Decedent's Edu			andanta Haval Osav			40h Kind - 4 D	Whit		
withly ane. then	Completed by	(Specify only highast grad Elementary/Secondary (0-12)	a com <i>pleted)</i> College (1-4or	5+) (Gi	cedent's Usual Occu va kind of work done b. DO NOT use retire acher	pation during most of work ad)	ing	Schoo		itry	
Hygie ther ther	Ö	17. Father's Name (First, Middle, Last)	_+	16	acher	18. Mother's Name	a (First Middle I				
ould be Mental arked o	Be C	Lazar Nisimov					ljaquev		10)		
d Me mark mati	7	19a. Informant's Name/Relationship (T	ma Printl	10h M	ilina Address /Stree				Ctata Zia C	ada!	
d 2 sho th end 7 la ma traum		Irina Shamailova	, , , till, ,			Terrace		, Only or Town,	31818, ZIP C	700)	
permit. Peges 1 end 2 should Department of Health end Mer Important: If item 27 la marke any injury or other traumatic 2006.		20a. Method of Disposition		20b. Piace of Dis	kville, I sposition (Neme of remetory or other ple	Maryland	20833 Dete	20c. Location -	City or Town	ı. State	
bernit. Pages 1 el Depertment of Hae mportant: If item iny Injury or other		1 Burial 2 ☐ Cremation 3 ☐ F			remetory or other ple Memorial		/1999				
permit. Pe Depertmen Important: any injury		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service Licens		Judean				Olney,	Maryl	and	
permit. I Depertm Importar any Injur		Canall 1	K			EW MEMORIAL STREET,					
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that causa	d the death. Do not	enter the mode of dy	ing, such as cardiac	or respiretory erro	est,	A	pproximata itervel Between	
Physician		orioni, or rioni ransio. Elst only o	t						Ö	nset and Deeth	
/Medical		Immediete Cause (Finai disaasa or condition	120	11 (0	nce		Two Je				
Examiner		rasulting in death)		Due o (or as a con:	sequence of):		-		10	70 10-	
D =	ner			5	,				¥		
ificate be executed g physician end es the buriel-transit	edical Examiner	Sequentially list conditions,	0. ————	Due to (or as a cons	sequence of):						
flicate be exe g physiclan e	E .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
ate b hysic	lica	that initiated events resulting in death) Lest	D	Due to (or es e cons	equence of):				1		
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0 0 %	lys	Part II. Other algnificant conditiona con	itributing to death I	out not resulting in the	underlying cause gi	iven in Part I.				ne cause of death?	
uires thet the de signed by the e	by Pi						1 U Y	es 2 No	3 Probat	bly 4 ☐ Unknown	
aw requests been 2 shou	Completed						24e. Was a periorr	n autopsy ned?	availa	autopsy findings able prior to pietion of cause ath?	
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	Be C	25. Was case referred to medical				26. Place of Deet	h (Check only on	, ,			
ysician: The li s certificete he director, pege	To B	examiner?	lospital:	ient 2 ER/Outpat	ient 3□ DOA Ot	her	me 5 Reside		er (Specify)		
iding Phy th. : After this s funeral o		27. Manner of Deeth 12 Natural 5 Pending 2 Accidant investigation		28d. Describe ho							
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificet completely filled in by the funeral director, page 200.	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (St City or Town		per or Rurel R	louta Number,	
Hospit 24 hours Funera etely fille	edical (29a. Certifier (Check only one) 15 Certifying Physical Exami	sicien: To the best ner: On the basis of and manner si	of my knowledge, de of examination end/or tated.	ath occurred at the ti investigation, in my	me, date and place, opinion, death occurr	end due to the cared at the time, da	ause(s) and ma ate and plece,	anner as state and due to th	ed. ne cause(s)	
o the	Me	29b. Signature end title of certifier	110	/	29c. Licen	se number	2	9d. Date signe	d (Month, De	y, Year)	
- 3 - 0		V 0 11	MILL	100	03	33686	1	March	9,10	300	
3)		30. Name end eddress of person who co					007		,	00000	
		Kenneth D. Miller,			ce Phillip	Drive, #	327, Olr	ney, Ma	ryland	20832	
Sta	ate	31. Date filed (Month, Pay, Yeer) MAR 1 2 1999	37. Regist	rar's Signature	1 .	k					

State of Maryland / Department of Health and Mental Hygiene

	,	Certificate	of Death	Re	g. No.	11364
1. Decedent's Name (First, Middla, La	st)			2. Deta of Deeth		3. Time of Deeth
ysician All III Z	NIINI	07		Month	Dey Preer	10:55PM
edical 4e Fecility Name (If not institution, given	a street end number)		4b. City, Town, or L	ocation of Deeth	4c. County of Death	
n. O	ge Hospital	Center	dhough	1.7	PriNCO	Georg e
E Social Sequeity Number 6 9	7 day on we lost	birthday) If Under 1 Y		8. Data of Birth (Month, Dey,		
2111-15-2700	1 M 2 F 69	Yrs. Months D	Deys Hours Min.	78 7	- 20 / 20/	placa (Stelle or Foraign intry) 10 POP
Usuel Residence of Decedent	- 01			1-70	30 00	1.1161.
10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
5 Maulaid Prince	Caro Dis	· loushus	a			1 Yes 2 No
10e. Street and Number	George Die	10f. Zip Co	ode .	10	g. Citizen of Whet Cou	untry?
0 11112 17	1 Plana	10112400	7/4		115 4	1.
7113 3300	- 1/400	20	// O	it-Vac as Na	14. Race - Amar	ican Indian
11. Marital Status	12. Was Decedent Evar in U,S. Armed Forces?	If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puarto	Rican, etc.)	Black, Whita	
. /	1 ☐ Yas 2 No If Yes, Give	Yes 2	No Specify:	20110	Specify: /	22.10
3 Widowed 4 □ Divorced	Year or Detes:		HA	MIVIC	APS	CANC.
15. Decedent's E (Specify only highest gr.	ducetion 16 ade completed)	Se. Decedent's Usuel C (Give kind of work of	occupation done during most of work retired)	king	6b. Kind of Business/	ndustry
15. Decedent's E (Specify only highest gr.	College (1-4or 5+)	11 - 10	retired)		own Hor	ME
3 RC grade		house hee	pt			
17. Fether's Neme (First, Middle, Last			18. Mother's Nam	ne (First, Middle, M	leiden Sumema)	
1 eotito	Ferreira		Kamo	Na N	IUNEZ_	
19a. Informent's Neme/Relationship	Type, Print) 1	9b. Meiling Address (S	Street end Number or Ru	rel Route Number,	City or Town, Stete, Z	ip Code)
Ramon G	NUNEZ	4113.53	Rd Pl	Bladen	sburg MT	20710
20a. Method of Disposition	20b. Place	of Disposition (Nema	of project)	Dete 2	Oc. Location - City or	fown, State
1 Buriel 2 Cremetion 3 4 Donation 5 Other (Speci	Removel from Stata	ti 20% D	om Pop	5-9-99	BONAO	Dem Ref.
21. Signature of Fundral Service Libe		Neme and A	Address of Fecility		FUNERAL	
1 ///	The		1/ 1/4/25	4 11109	11-6-10-1	Dervice
1994	Music		Lewil WURT			
23a. Part : Enter the disease, or com shock, or heart failure. List only	plications that causad the death. Done ceuse on each line.	o not antar tha moda o	of dying, such es cardiac	or raspiratory erre	st,	Approximata Interval Between
1	2 1		,	1		Onset end Death
Immediate Ceuse (Final disease or condition	· Cardio	resvolve	a ton	HVV	est	Unknown
resulting In death)	Due to (or es	e consequence of):		^		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	. Fud	Stage	Renal	Dife	ase	()
Sequentially list conditions,	Due to (or es	e consequence of):				
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Acul	Le Res	nivelan	Fa	1/1/28	1/
Ceuse (Disease or Injury that initieted events resulting In daeth) Last	C. Due to (or as	e consequence of):	1100	7 1		
e lessifing in destri) East						
Pert II. Other eignificant conditions	d					
Pert II. Other eignificant conditions	contributing to death but not resulting	g in the underlying ceus	se given in Pert i.	23b. Did to	bacco uee contribute	to the cause of death
				1 Ye	8 2 No 3 P	obably 4 Unknow
						^
				24a. Was ar		Were eutopsy findings available prior to
				perform		completion of ceuse of deeth?
				45.4		
				1 □ Ye		1 ☐ Yes 2 No
25. Wes cese referred to medical examiner?	Hospital:		Othor	th (Check only on		
1 Yes 2 No	1 pas Inpatient 2 LER/	Outpetient 3 DOA	4 Li Nursing H		nce 6 Other (Spe	cify)
27. Manner of Death	(Month, Dey Year)		. Injury et Work?	280. Describe no	w injury occurred	
2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
4 Homicide determined	28e. Plece of Injury - At home, building, etc. (Specify)	, farm, street, fectory, o	office	City or Town	reet end Number or Ru , Stete)	irel Houte Number,
27. Manner of Death 1 Neturel 2						
29a. Certifier (Check only one) Certifier 2 Medical Extended	ysician: To the best of my knowled miner: On the besis of exemination	ige, death occurred at t	the time, data and place	, end due to the ce	use(s) end menner as	steled.
one)	end menner steted.	endor investigation, in	my opinion, deam occu	rred et tire tille, de	ite eno piace, eno oue	to the cedec(s)
29b. Signature and title of Certifier	- 100		icansa number		9d. Data signad (Month	h, Day, Year)
1/1/1/	11 le thish	1100	V 792 0	5	3/13/99	Y
30. Name and audiress of person who	completed cause of death (Item 23	e) (Type, Print)	DZ920		1 / / /	
pricy or	2061N SON	PRINER 1	STEDDEE!	115.10	CENTS.	n
	32. Registrer's Signatura			1 - 6		
State 31. Date filed Month, Day, Yeer)	Banne	4 1	-			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death	F	leg. No.					
	1. Decedent's Nama (First, Middle, La	st)					2. Date of Dea Month	th Day	Yaar	3. Time of De			
Physician /Medical	Philip	Louis No	agle,	Jr.			March		999	9:00			
Examiner	4a Facility Nama (If not institution, giv	a street and number)				4b. City, Town, or	Location of Death	4c. County	of Death				
	2841 Snydersburg	Road				Hampste		•	Carro	11			
Funeral Director	213-12-3033	Sax 7. Age	(In yrs. last b	Yrs. If Und Month	dar 1 Yaar s Days			, Year) , 1916	Count	ace (State or Fo ry) yland			
and tand	Usual Residenca of Decedent 10a. State 10b. County		10c. City, To	wn or Location					10	d. Inside City L			
e-fish fred ctor	Maryland Carrol	.1				Hampst	ead			1 ☐ Yes 🍇			
fier death with the Ma ricer must be notified funeral Director	10e. Street and Number 2841 Snydersburg	Road		10f. 2	Zip Code	21074		l 0g. Citizen of V	Whet Count USA	ry?			
by by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yas 2 N If Yes, Give Year or Dates:			cedant of I becify Cub 2 No	Hispanic Origin? (S ean, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Rac Biad Specify	e - America k, Whita, a				
72 ho	15. Decedent's E- (Specify only highast gre		16	e. Decedent's Us (Giva kind of	work done	pation during most of world)	rking	16b. Kind of Bu	siness/Ind	ustry			
ed within 72 hou ygiene. Nor than "nature it, the Wedeal!	Elementery/Secondary (0-12)	Coilege (1-4or 5	+)	Owne:		od)		Ice C	ream :	Store			
Hygie Ther to Co	17. Father's Name (First, Middle, Last)		OWITC.		18. Mothar's Nar	me (First, Middle,			DCOLC			
antai H	Philip Louis Nac						beth Ble						
should it	19e. Informent's Name/Reletionship (19	b. Mailing Addre	ess (Stree	t and Number or Ru			Stata, Zip	Code)			
od 2 selfth ar lith ar trau	Marjorie Nagle,					sburg Rd,							
permit. Pages 1 and 2 Department of Health Important: If them 27 I any Injury or other tra pnce.	20e. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemet	of Disposition (A ery, crematory of ersburg	r other pla		Date 3/18	20c. Location -					
permit. Pag Department Important: I any Injury o pnce.	21. Signature of Funeral Service Lice	0 -	lune	22. Name	end Addre		Eline Fu St, Hamp	neral H	ome				
death certificate be executed e attending physician and nd for use as the bunal-transit sician/Medical Examiner	Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b											
th certification tending or use as		d											
the dee	Part II. Other algnificant conditions of	contributing to deeth be	ut not resulting	in the underlyln	g cause gi	iven in Part I.	23b. Dld t	obacco use co	ntribute to	the cause of d			
gned to be dett	Parkinson's	Disease					101	res 2000	3 Prob	ebly 4 Uni			
aw requise been 2 shoul	Dementia						24e. Was perio	en eutopsy med?	ava	are eutopsy find allable prior to appletion of caus death?			
ysician: The last contribution of the contribu	Hypertensive	Cardiova	ascula	r Dise	ase		101	es 2000	1 🗆	Yas 2□ No			
certificate rector, pag	25. Was casa referred to medical examiner?						eth (Check only o	ne)					
After thi funeral	1 Ves 28 No	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			28c. Inju			ome 5 Besidence 6 Other (Specify) 28d. Describe how injury occurred					
tal or Attanding P rs after death. al Director: After t led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	One Diese of init	ury - At home, c. (Specify)	ferm, street, fac	tory, office		28f. Location (5 City or Tox	Street end Numb m, Stete)	per or Rura	l Route Number			
Tan E	29a. Certifier (Check only one) 1 Certifying Pt	ime, date and plece opinion, deeth occ	e, and due to the urred at the time,	ceuse(s) end mo dete end place,	enner as st end due to	eted. the ceuse(s)							
• Hospital 5.24 hours 6. Funeral bletely filled	Griej												
To the Hospi within 24 hou To the Funer completely fil		29b. Signeture end title of certifier 29c. License nun D/U								29d. Date signed (Month, Day, Year)			
2024	29b. Signeture end title of certifier	ausar,	Ach		DI	140/		3/16/	99				
To the Hosy within 24 ho To the Fune completely I) (Type, Print)	17 1								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Month **Physician** OLUYEMI ODESINA 1999 8:07 PM March 15 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Deys Hours 43 Yrs 042-92-8443 October 4, 1955 Director Nigeria, W.A. Usual Rasidance of Decedan the Merylenc 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits worle r than "natural", or items 23s or 28s-f ehor the Medical Examiner must be notified at 1 X Yas 2 No Maryland Prince George's Directo Beltsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? With 3580 Powder Mill Road, Apt #204 20705 Nigeria, West Africa deeth Funeral 12. Was Decedant Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 ☑ No
If Yes, Giva
Yaar or Datas: 14. Race - Amarican Indian Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours efter 1 Naver Marriad 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacadent's Education (Spacify only highest grade completed) Hygiene. Collega (1-4or 5+) Elemantary/Secondary (0-12) Private Nurse 4 vears traumatic avent. 18. Mother's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Peges 1 and 2 should be fill ment of Heelth and Mental Hyant: if Item 27 ie marked oth Be Esther Makinde Oluwole Adequile 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) Timothy Odesina/Husband 3580 Powder Mill Road, #204, Beltsville, MD 20705 other 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Cemetery 03/27 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Peges
Department of
Important: if it
any injury or c W.A. 1 Burial 2 Cramation 3 K Ramoval from State Umca Jerusalem Church 4 ☐ Donation 5 ☐ Othar (Spacify) Igbeti, Oyo, Nigeria, J. B. JENKINS FUNERAL HOME 21. Signeture of Funeral Service Licenses le ce 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the diarrale, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Betwaan Onset end Deeth **Physician** /Medical Immediata Causa (Final Cardiac Arrest disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner Diabetes Mellitus that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in daeth) Last and Dua to (or es e consequença of) P.O. Box 68760. physician Physician/Medicai the Due to (or es e consequence of) 98 ettending 980 ò 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the ed by the 21 No 3 Probably 4 Unknown 1 Yes Records, þ Sign P 24b. Were autopsy findings evailabla prior to completion of cause of death? Completed 24e. Was en autopsy peed , page 2 hes 1 TYas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was casa referred to medical Be 26. Pleca of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 9 1 Yas 2X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Daath 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Certification: 5 Panding 1 X Natural 1 Yas 2 No invastigation 2 Accidant 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 D Homicide 24 hours a 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted.

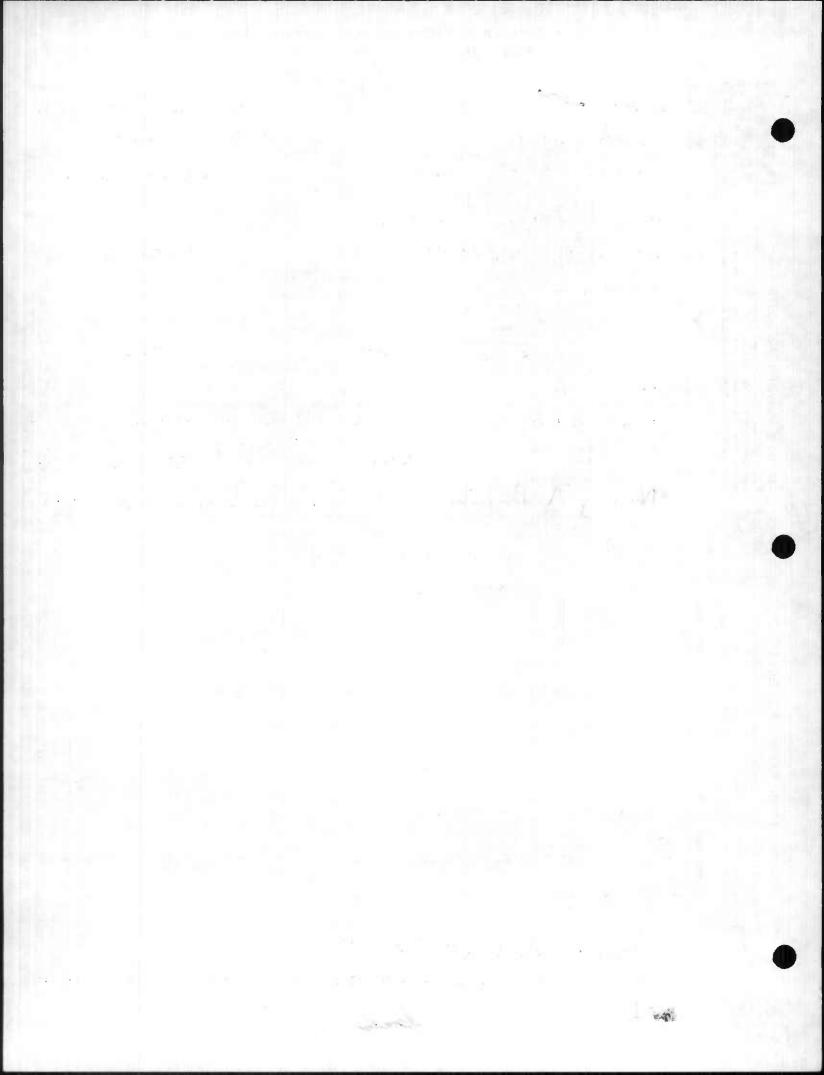
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the To the 29b. Signeture end title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D0052761 March 19, 1999 30. Name end eddrass of person who complated causa of daath (Itam 23a) (Type, Print) Martha I. Bennett, M.D., 12201 Plum Orchard Drive, Silver Spring, Maryland 20910 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

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DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Physician : 00 AM March 20 1999 AANE /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Bruth More If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) HOSPITAL 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. jast birthday) **Funeral** 1 M 2 D Months Deys 220-30-1306 Director ULY 26 1934 Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland nant of Health and Mentel hygiene. Int: If item 27 is a marked other than "nature", or items 23s or 23s-1 show uny or other transmit be notified allow uny or other transmit be notified at 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No Director 10e. Street and Number 10l. Zip Code 10g. Citizen of What Country? USA Funeral 12. Wes Decedent Ever Armed Forces? 1 Yes 2 DNo 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indien, in U.S Bleck, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1□ Yes 2 No If Yes, Give Year or Dates: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working , [life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OMEMAKER WN TOME 17. Father's Name (First, Micplie, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) TORSUC AMILLA 19a, Informent's Neme/Reletionship (Type, Print) KURT OF | A 4 1/4 A 1/4 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) 19b Mailing Address (Street and Number or Flural Route Number, City or Town, Stele, Zip Code) Depertment of Health ar Important: If item 27 is eny injury or other trau page. 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 ☐Remoyal-from Stete FINKSBURG, Mb. 4 ☐ Donation 5 ☐ Other (Specific 21. Signature of Fuperal Service Lice 22. Name and Address of Fecility PCHS FUNERAL HOME Chapel 412 WASHINGTON ROAD 23a. Pert1. Enter the disease, or complications thet caused be death. Do not shock, or heart tallure. List only one cause on each time. Approximete Intervel Between Onset end Deeth Physician /Medical tmmediate Cause (Finel disease or condition resulting in death) NEEKS Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Netural 2 Accident To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

DHMH 16 Rev 6/95

State Registrar

NAME

AGNES

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUTOMBO
31. Date filed (Month, Day, Year)

MAR 2 2 1999

KANKONDE

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

		Certificate			Reg. No.	1.0	7.4.0
Physicia	an	1. Decedent's Name (First, Middle, Last) WILLIAM PETERS		2. Deta of Da Month	Dey	Yeer	3. Time of Death
/Medic Examin	- 11	4e. Fecility Name (If not institution, give street end number)	4b. City, Town, or L	ocation of Deet	h 4c. County	99	4.10AA
Funeral Director	er	1,00051DE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Y 5. 77-20-7959 100 M 2 F 73 Yrs. Months Di	SILVE	8. Date of Bir	M	on	TGOMERY ice (State or Foreign V) USA
dand w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				100	d. fnside City Limits
the Merylan 28a-f show nouted at	tor	D.C Washington District o	F COL	umb	9		1∏ Yes 2□ No
or 28	Oire.	10e. Street end Number 10f. Zip Cod	de		10g. Citizen of	Whet Country	y?
ath w	ral	1350 ADAMS STREET NE	20018		U	LSA	
000	by Funeral Director	11. Marital Stetus 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent If Yes, specify 0 4 Yes, Give 1 □ Yes 2 ☑ Year or Detes:	of Hispenic Origin? (Sp Cuben, Mexicen, Puerto No Specity:	pecify Yes or No o Rican, etc.)	Bla Specif	ce - American ck, White, et	
"natural",		15. Decedent's Education 16e. Decedent's Usual Or	ccupetion		16b. Kind of B		
d within r than r than	Completed	(Specify only highest grade completed) Elamantary/Secondary (0-12) 12 YEARS Collage (1-4or 5+) NONE (Giva kind of work de liffe. DO NOT use re PHOTOGRAPHE	one during most of work atired) CR	king	PHOT	OURA	otry
d out	To Be	17. Fether's Neme (First, Middle, Last) BRADFORD PETERS, SR.	18. Mother's Nem	GARLAN		ne)	
nd 2 sh aith and 27 is m r traum		19a. Informent's Neme/Relationship (Type, Print) CANDICE YOUNG(DAUGHTER) 19b. Mailing Address (St. 813 CRITTEN)				Stete, Zip C)18	iode)
mit Pages 1 a commit of Head		20a. Method of Disposition XX Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify)	of placa) METERY 3/1	Date L8/99	20c. Location BRENTW		
Departs Imports any inja once		21. Signature of Funeral Service Licensee	ddress of Fecility JOF	IN T. RI 30 12TH		-	
physicia the bur	edical Examiner	Immediata Causa (Final disease or condition resulting in deeth) e. CULLIMOUS CELL COVC Due to (or es e consequence of): b. Due to (or es e consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of):			lung		
	2	d				-	
been signed by the attendingshould be detached for use	by Physician/M	Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause Diabetes mellitus	e given In Pert I.	\			he cause of death?
been s	Completed by	Renal insufficiency		24a. Wes	en eutopsy rmed?	eveil	e autopsy findings eble prior to plation of cause
ate hes b	E	Essential hypertension		10	Yes 2 No	10	
ortifica ctor,	Be	25. Wes case referred to medical exeminer?	26. Place of Deer	th (Check only o	one)	1	
his ce	2	1 ☐ Yes 2 No Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA		ome 5 Resi			
To use negation of separation of the levi man in the levi within 24 hours after deeth. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	Stature 5 Pending (Month, Dey Year) Injury	Injury et Work? 1 Yes 2 No		how Injury occur		
I o the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi	Certif	4 Homicida determined building, etc. (Specify)		City or To			
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifiar (Check only one) Certifying Physicien: To tha bast of my knowledge, daath occurred at the decision of examinetion end/or investigation, in n end manner stated.	a tima, data end pleca, ny opinion, death occur	end due to tha red et the time,	causa(s) and ma data end place,	annar as stat end due to ti	ed. he cause(s)
To t com	Σ	296. Signature and title of cartifier Wanglas ms, 29c. Lie	cense number 1D 11593		1 Maril	a pare	y, Year) 1999
(0)		30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) Pill Cle Sand Avenue, NE	, Wash	ingte	n, D.	C. 2	0018
State	-	31. Dete filed (Month, Day, Year) MAR 1 6 1999 32. Registrer's Signature		/			

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				State of Ma	•	epartmen Certificat			and M		ene 99	1	0929	
	1	_	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Deeth	
	Physiciar /Medica		Geneva Patterson	n						March		1999	12:15AM	
	Examine		4a Facility Name (If not institution, give st					4b. City, To	wn, or L	ocation of Death	4c. County	of Death		
			Prince George's I	-		day) If Under	1 Voor	Cheve		0.000.400.0	Princ			
L	Funeral Director		5. Social Security Number 223-64-4463 Usual Residence of Decedent	M 2DAF	(In yrs. last birth	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Feb. 17,			lace (State or Foreign try) ginia	
	h the Meryland		10a. State 10b. County Maryland Prince Geo		10c. City, Town	or Location Temple	e Hi	.11s				1	0d. Inside City Limits 1 X Yes 2 No	
	h with the	5	10e. Street and Number 4423 - 23rd Parks	vay #1	04	101. Zip		0748		10	g. Citizen of V			
020	IIS	by rur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec			gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	Biad	Bla	etc.	
5-0	natural',	De l	15. Decedent's Educe (Specify only highest grade	ation completed)	16a. [ecedent's Usua	al Occup	pation during mos	of work	ina 1	6b. Kind of Bu	siness/Inc	dustry	
21215-0020	d within giene. r than	Completed	Elementary/Secondary (0-12) 12th	Coilege (1-4or 5+)	Give kind of wo ife. DO NOT us Nursi				9	P	rivat	ce	
pu		e n	17. Father's Name (First, Middle, Last)					18. Mothe	r's Nam	Private (First, Middle, Maiden Sumame) ary Marie Gray (Route Number, City or Town, State, Zip Code) 104; Temple Hills, MD 20748 Date 20c. Location - City or Town, State				
Maryland		0	Lea Andrew Sh											
Mar	0 0 0 0		19e. Informant's Name/Relationship (Type Brenda Shoemaker											
	s 1 end f Health fam 27 other tr	-	20a. Method of Disposition	- Daugnte		Disposition (Ner		rarkw	ay,		-			
altimore,	m 0 -		1 ☐ Burial 2 ☆ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from Stata	cemetery	s Crema	ther pla		3	/13/99				
Ball	pemit. Page Department of Important: If any injury or pnge.		21. Signature of Funeral Service Licenside 22. Name and Address of Facility 4001 Benning Rd											
Vita a	Physician		23a. Part 1. Enter the disease, or complic shock, of heart feilure. List only one	ations that ceused to cause on each line	he death. Do no	t enter the mod	e of dy	ng, such as	cerdiac	or respiratory arre	st,	1	Approximate Interval Between Onset end Deeth	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	CARDIS	RESP	RATT			re	830		1	5 MIN	
-	nsit nsit	Examiner	Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):								THY	1		
90,			Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury c.	D	ue to (or as a co	insequence of):								
68760,	ng physician s es the buria	rnysiciarymedical	that initiated events resulting in death) Last	D	ue to (or as a co	nsequence of):								
Box	death certific	200	d.									1		
0.	the elf	310	Part II. Other significant conditions conti	ibuting to death but	not resulting In	he underlying c	euse gi	ven in Pert I		23b. Dld tot	acco use co	ntribute to	the cause of death?	
0	s the	2	HIV INFEC	MOR						1 To	2 2 No	3 Prol	bably 4 ☐ Unknown	
of Vital Records,	law requires les been sign	paraidillos								24a. Was an perform	autopsy ed?	av	ere autopsy findings allable prior to mpletion of ceuse deeth?	
R	The law	5								1 □ Ye	s Mino	1[Yes 2 No	
ita	ysician: The		25. Was cese referred to medicei exeminer?					26. Piace	of Deal	th (Check only one)			
7 <	2 00	2	1 ☐ Yes ₹ No	spital: Impatien	t 2 ER/Out		JA		irsing Ho	ome 5 Reside			y)	
	Attending Ph r death. ector: After th by the funeral	a long	27. Menner of Death 1 Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of 2 ury M	28c. Inju Wo 1 □	ryat rk?]Yes 2□	No	28d. Describe ho	w injury occur	red		
Division	s ofter death	27. Menner of Death 27. Menner of Death 28a. Date of Injury 28b. Time of Injury								281. Location (Str City or Town,		er or Rure	al Route Number,	
	Hospi 24 hour Funer stely fil	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.										teted. the cause(s)		
	To the within 2 to the comple	-	29b. Signature and fille of certifier	A		290	. Licen	se number		29	d. Date signe	d (Month,	Day, Year)	
1	7		I suda h	20	len 4	D	D	214	12	8	3/1	1/9	9	
(3/		30. Name and address of person who com Linda D. (a1 D	rive,	Che	verly, M	D			

Registrar

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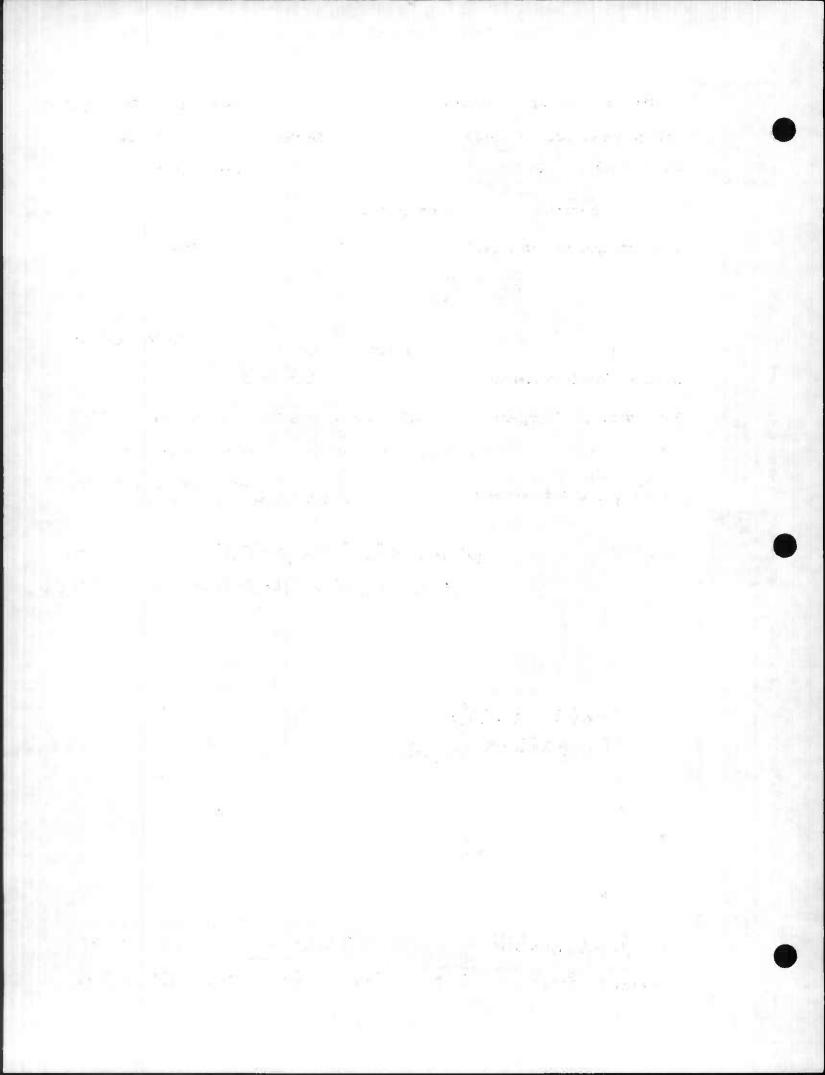
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 17 Day Charles Leroy Peeling 1999 9:00am /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3801 Schnaper Dr. Apt #103 Randallstown Baltimore 5. Social Security Number 215–18–4687 If Under 1 Year 8. Dete of Birth (Month, Dey, Yeer) Aug 16 191 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Months Days Hours 82 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Manylen ent of Hauth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show may or other the transpace of the Manyle 1 any or other the unsaft of event, the Medical Experience means the notified a my or other the unsaft of event, the Medical Experience. Randallstown Md Baltimore 1 ☐ Yes XXNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Schnaper Dr. Apt. #103 21133 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1936—
12 Yes, 2 I No 1940
tf Yes, Give Year or Dates: 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) transportation College (1-4or 5+) railroad breakman 11 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last)
Charles Cleveland Peeling Alma Wall 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Joyce Nickoles (daughter) 1405 Hoffman Home Rd., Littlestown, Pa. 17340 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Dete 20a. Method of Disposition 1 Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any injury or once. Providence Cemetery 3-20-99 Gamber, Md 21. Signature of Funeral Servica Licansee 22. Name end Address of Facility Haight Funeral Home & Chapel Parge Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Ses 980 signed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy After this certificate hes funaral director, page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certifica 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) investigation To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner as steled.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

ROJACO REFERER 850 (LIF BALT MO IBERTY 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Deneva MAR 1 8 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 149999 6:25 PM March Thomas Bernard Parker Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Mary's Hospital St. Mary's Leonardtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 10XM 2□ F Months Days Hours Yrs. 216-12-4632 77 October 21,1921 Maryland Director Usual Residence of Deceden the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Marical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 38189 Sugar Hole Road 20609 U.S.A. e filed within 72 hours efter death al Hygiene. other than "natural", or items 23. Funera 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Black Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Comp Elementary/Secondery (0-12) College (1-4or 5+) 8th Labor Construction permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, Important: If Itam 27 is marked othe any injury or other traumatic event, bace. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Elizabeth Shelton Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia Parker/Spouse P.O. Box 114, Abell, MD 20606 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 3/22/99 Sacred Heart Cemetery Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. pool enter the mode of dying, such as cerdiac or respiratory arrest, P.O. Box 270, Leonardtown, MD 20650 chall 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one churs on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final RosiATE CANCER disease or condition resulting in death) Examiner Examiner physician end s the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) 88 attending for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached 3 Probably 4 Unknown 1 Yee 2 No signed by CANCER 20 8 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy peen : has N paga . 1 Yes After this cartificate or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes No
27. Manper of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completaly filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) BOX 1753 LEONARDTOWN, MD. 20650 WILLIAM BOYDIIM.D. 31. Date filed (Month Max Year) 3 32. Registrar's Signeture

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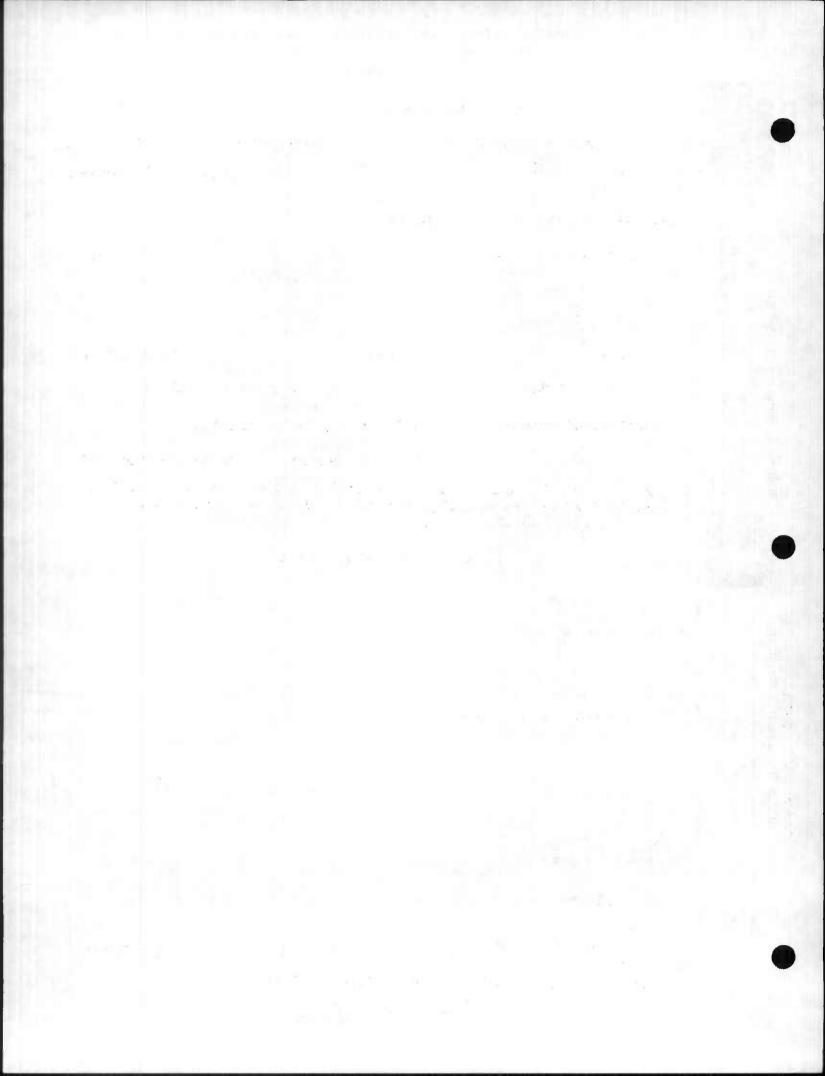
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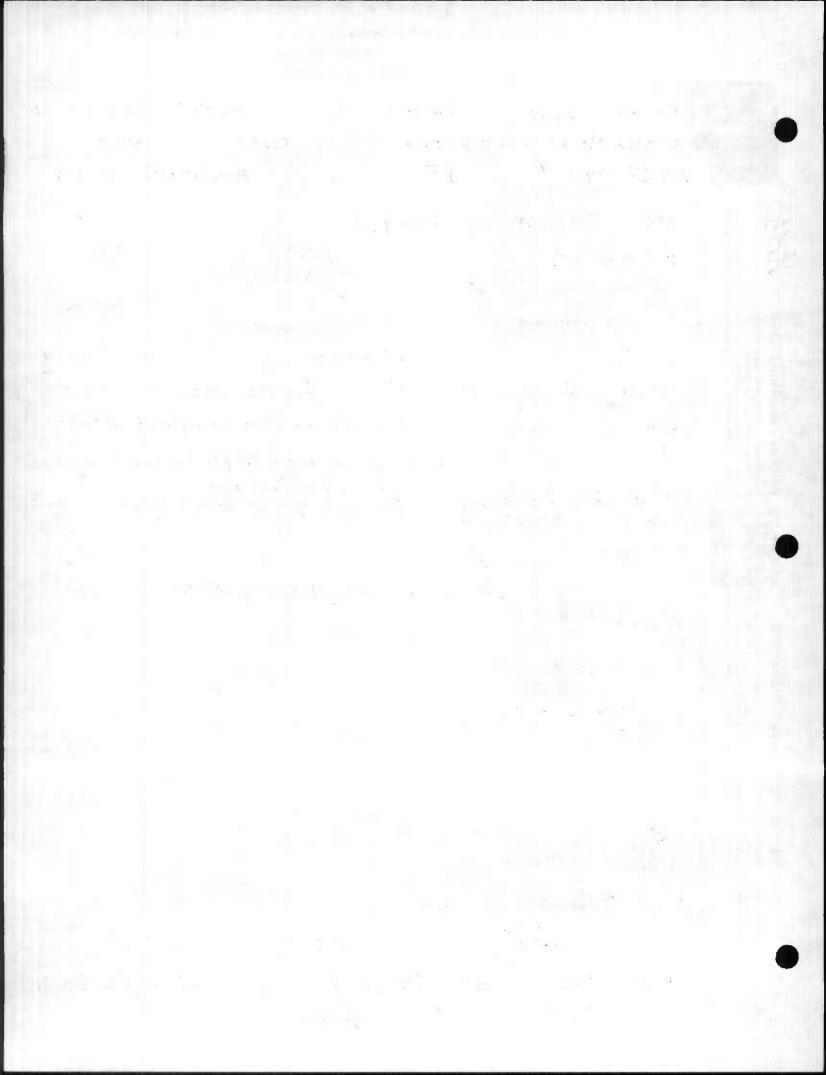
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death DINKett 4.38 pm 500ds:1 Bishop March 1999 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Cambridge Hunder 1 Year If Under 24 Hrs. 8. Days of Birth (Month, Pey, HOSPi orchester Genera Dorchester 6. Sex 7. Age (In yrs, lest birthday) 5. Social Security Number Birthplece (State or Foreign Country) 219-14-3908 Usual Residence of Decedent Year) 12M 2DF Yrs. 1908 MarylanD APR: 127 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Dorchester ambiridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 D No If Yes, Give Yeer or Dates: 80 21613 RYMAN 45 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) DRIVER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) infield Martha Hackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Pinkett ambridge MD 21613 Date Cochocation - City or Town, State 10/0 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 3/25/99 Bucktown Cemetery 22. Name and Address of Facility HENRY FUNERAL Cambridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home 23a. Pent/ Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset end Death Immediate Cause (Final weeks disease or condition resulting in death) neumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral Director

by

Completed

Funeral

Director

ns 23a or 28a-f must be notifie

T is marked other than "natural", or then traumatic event, the Medical Examiner

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Pages 1 and 2 should be Illed within nent of Health and Mental Hygiene, int: If Item 27 is resriced other than ",

Department of Important: If

altimore, Maryland 21215-0020

physician and the burial-transit attending p been signed by the should be detached page 2 s

 Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifice funeral director,

Division of Vital Records, P.O. Box 68760,

p Completed Be 2

Medical

Examiner Physician/Medical Certification:

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

27. Menner of Death

1 Natural

6 Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

aulou

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and menner as steted.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 214349

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Dey, Year)

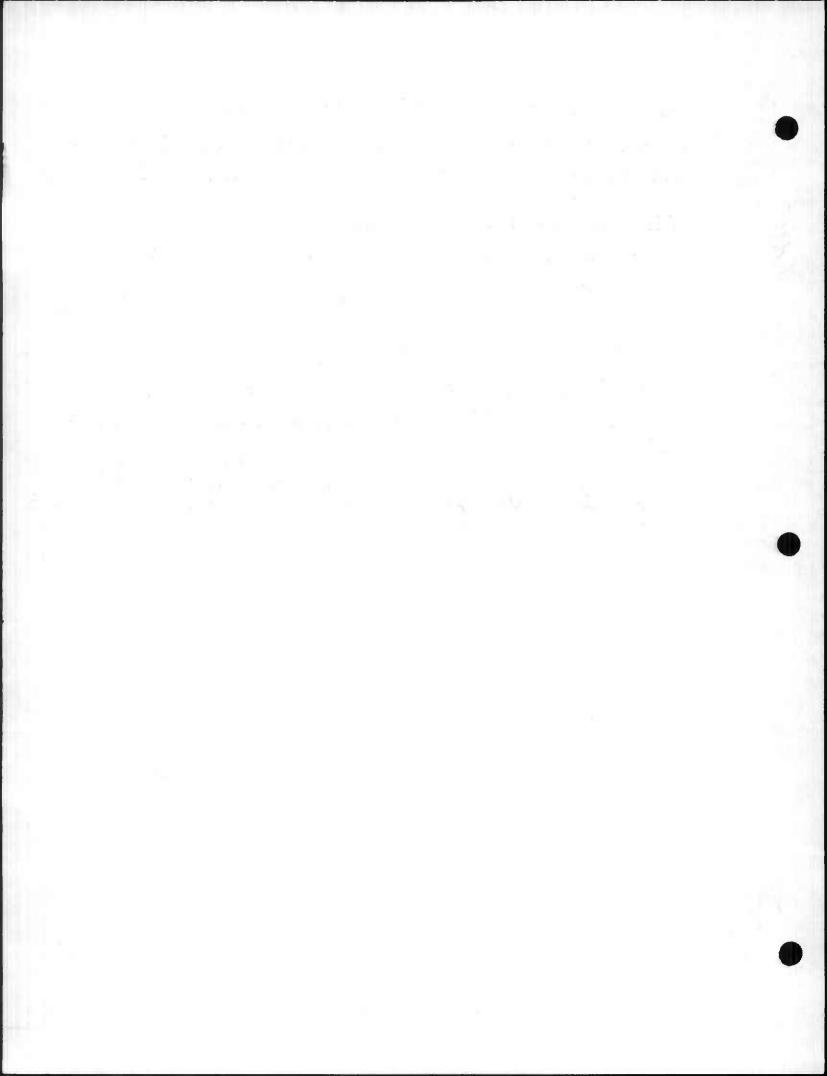
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin St. Campridge, MD 21613 MD

Tanman

31. Date filed (Month, Day, Year) MAR 2 4 1999 32. Registrar's Signature

State Registrar

To the To the To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dev **Physician** 16, 1999 Cephas L. Robinson March 6:07 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9 Birtholece (State or Foreign **Funeral** Months Hours Commonwealth Of Devs 218-21-2989 78 22, 1920 Director Usual Residence of Decedant 10c City Town or Location 10d Inside City Limits 10a State 10b Counts r than "natural", or itsms 23e or 28e-f show the Medical Examiner must be notified at 1 No Yes 2 No Maryland | Prince Georges Directo Hvattsville 10g. Citizen of Whet Country? Commonwealth Of 10e. Street and Number 10f. Zip Code 2111 Guilford Rd. #201 20783 Dominica Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 Specify: Specify: Black P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Hygiene, other than Elementery/Secondery (0-12) College (1-4or 5+) 0 Construction Self-Employed 18. Mother's Name (First, Middle, Maiden Sumeme) 17 Fether's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hart: If Item 27 is merked oth Jury or other traumatic event 86 Ellis Robinson Floresca Joseph 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 2111 Guilford Rd. # 201 Hyattsville, MD 20783 Ernestina Robinson (Wife) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Commonwealth Of 1 Burial 2 Cremetion 3 Removel from State Department of important: If Wesley Catholic Cemetery3/27/99 4 Donetion 5 Other (Specify) Dominica 21. Signature of Edneral Suprice Licensee 22. Name and Address of Fecility Kendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** (or es e consequença of) Examiner that the death certificate be executed physician and the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): PREPIANDAY FAMILE DUE 50 10-15 min AM1010 use CANLER OF PROSTIFE signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes V No 3 Probably 4 Unknown p 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed certificate has b lirector, page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director, 25. Wes case referred to medical examiner? Be 26. Pieca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 2 1 Tes No No 1 Inpatient 3 DOA funeral 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide of the Ho.
To the Funeral L.
To the Funeral L.
To the Funeral L. for Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as stated.

2 ☐ Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated. 29e. Certifier Medicai 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of pertifier 29c. License number

State Registrar 31. Dete filed (Month, Day, Yeer)

1 9 1999

SAMUBL

30. Name and eddress of person who completed cause

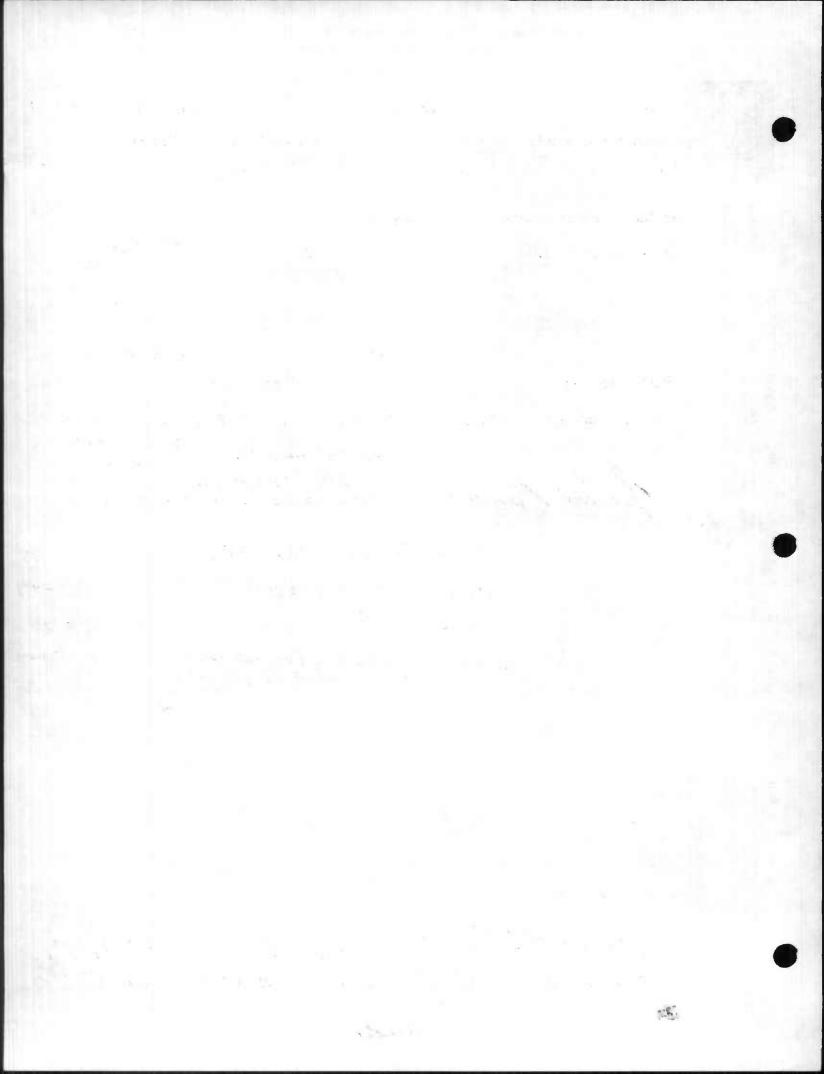
32. Registrer's Signeture

S. Sparle

COURSER PK

of deeth (Item 23a) (Type, Print)

m,D



			Certificate of Death	, ,	eg. No.	10935
	Physic /Medi	cai	Decedent's Name (First, Middle, Last) George Rosen	2. Date of Deal Month March	Day 1999	
	Exami Funeral Director	ner	4a. Facility Name (If not institution, give streat and numbar) 4b. City, Town, or Lot 9513 St. Andrew's Way 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 88 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 88 7. Age (In yrs. last birthday) 88	ning 8. Date of Birth (Month, Dey	4c. County of Monty on 9	nery Birthplace (Steta or Foreign Country)
		_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	April 12	2,1910 De	10d. Inside City Limits
	vith the M	Director	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda	1	0g. Citizan of Who	1 ☑ Yes 2 ☐ No at Country?
020	or ite	by Funeral	9513 St. And rew's Way 11. Marital Status 1□ Nevar Married 2□ Married 3□ Widowed 4□ Divorced 20901 12. Was Decedent Evar in U,S. Armed Forcas? 1□ Yes 2□ No If Yes, Giva Year or Dates: 1□ Yes 2□ No Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
21215-0020	c .	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cowner/Operator		16b. Kind of Busin	White ness/Industry Air Condition
Maryland	should be filed nd Mental Hygis marked other imatic event, to	To Be		(First, Middle,)	Maiden Sumeme) ein	
Baltimore, Ma	ges 1 and 2: it of Health ar If Item 27 is or other trau			Silver S	Spring, 1 20c. Location - Cit	AD 20901 y or Town, State
Balti	permit. Pa Departmen Important: eny Injury once.		21. Signature of Fund Server Sciences 22. Name and Address of Facility	- 1 E	Olney, Ma	
	Physician /Medicai Examiner	er	232 Carroll St. NW Lanck, of Memoria and M	r respiratory arri	est,	Approximata Interval Between Onset and Death DAYS
x 68760,	n certificate be axecuted anding physician and usa as the burial-transit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intilated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): ARCLIOMA OF STOM	TO L	-I VER	6 mos
P.O. Box	it the death certif by the attending tached for usa a	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld to	11	bute to the cause of deeth? Probably 4 Unknown
Ś	The law requiras that the death cert te has been signed by the attending paga 2 should be detached for usa	by		24a. Was a	n autopsy 2	4b. Ware autopsy findings available prior to completion of cause
of Vital Record		Be Completed	25. Was case referred to medical 26. Place of Deeth		s 2∏ No	of death? 1 □ Yes 2 ☒ No
	Phys	2	Askariliner / 1	ne 5 🖾 Reside	nce 6 D0ther (Specify)
Division	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune	al Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town	, Stete)	or Rurel Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and lite of certifier 29c. Licansa number Certifier (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29c. Licansa number	d at the time, da	ouse(s) end manner ate and place, and Od. Data signed (A	due to tha cause(s)
	(12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Item BERT A. MOSKOUTTIMB, 2021 K, ST. N. W.	5	March 15	1999
	Sta Registr	•	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-W. 17C	7

DI	9-1660-03 DG	Plea	se Type or P State of		Depar	rtment of I	Health and N		-	ole.	1936	
R.	ICHARD RE	ITEMS: #23 PART	I, 28A-F PER	MEO G770 4-	Cert	ificate of	Death	Re	g. No.			
		1. Decedent's Nama (First, Middle	a, Last)	711-10				2. Data of Death		Veer	3. Tima of Death	
	Physician	Richard		Reid				Month MARCH 1	Day 9. 1999	Year	0411 AM	
	/Medical Examiner	4a Facility Nama (If not institution	, giva street and numb				4b. City, Town, or L	1				
4	ZX	13107 WONDERLA	ND WAY # 5				GERMANTO	NWO	MONTO	OMER'	Y	
	Funeral Director	5. Social Sacurity Number 213–58–6367	6. Sax 1 X M 2 □ F	Aga (In yrs. last bii 49	Yrs.	If Undar 1 Yaar Months Days		8. Data of Birth (Month, Day, July 19,			aca (Stata or Foreign ry) ngton, DC	
	Pu .	Usual Rasidance of Dacedant 10a. Stata 10b. County		10c. City, Tow	n or Loca	ation				10	d. Insida City Limits	
	anyle show			100. 0119, 1011	III OI LOCA	ation				10	1 X Yas 2 □ No	
	s 1 and 2 should be filed within 72 hours efter death with the Maryland I Health and Mentel Hygiene. Item 27 is marked other than "naturel", or itema 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Maryland Montgo	omery		Germ	antown_		1/	g. Citizan of W	That Count	017	
	Nith Di		1 1	<i>IL</i> =		,	007/	"			.,,	
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	be filed other event, II Be Cc	17. Fathar's Nama (First, Middla,	Last)	18. Mothar's N					laidan Sumami	a)		
la	should be and Mentel or marked or urmetic eve	Ra1ph	Reid				Mildr	ed Re:	Reid			
Maryland	end ls me	19a. Informant's Name/Ralations	Stata, Zip	Coda)								
	1 end 1 Health em 27 other tr	Denise Densmore	e - Fiance				nd Way, #5,					
altimore,	Pege nent o any or	20a. Mathod of Disposition 1 🖫 Burial 2 🗆 Cramation 4 🗆 Donation 5 🗀 Other (S)	pecify)	ata camata	lry, crame Linc	ition (Nama of atory or other pluot oln Cem Nama and Addr	etery		Brentwo		Maryland	
Ba	Physician /Medical Examiner	23a Part : Enter the dispets or shock, or heart failure. Not Immediata Causa (Final disaasa or condition rasulting in death)			47 not entar	39 Balt tha moda of dy TION COMPL CARDIOVAS	uneral Ho imore Ave ing, such as cardiac LICATING HYP SCULAR DISEA	nue, Hya: or raspiratory arra	ist,	1	Approximata Intarval Batween Onsat and Daath	
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68760,	icete be executed physician end s the burel-transit	if any, laading to immadiata causa. Entar Undartying Causa (Disaase or injury that initiated avants rasulting In daath) Last	c	Dua to (or as a	consaqu	ance of):			-			
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0	e dea the eth hed fo	Part II. Other significant condition	ns contributing to deal	th but not rasulting I	n tha und	darlying causa g	ivan In Part I.	23b. Did to	bacco use con	ntributa to	the cause of death?	
α.	requires that the demen signed by the e hould be deteched found by Physic							1 🗆 Ye	2 □ No	3 ☐ Prob	ably 4 Unknown	
Records,	been should should							24a. Was a parform		ava	ra autopsy findings iilabla prior to nplation of causa laath?	
	The late he page							1 XY	s 2 No	1,8	Yas 2 No	
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ion of	Attending Ph or death. ector: After th by the funeral			Day Year) Foun	Tima of Injury	A We ME	ury at ork?] Yas 2 [[] No	28d. Dascribe ho UNKNOWN	w Injury occurr	ed		
Division	e Hospital or Attending Physician: The law 124 hours efter death. • Funeral Director: After this certificate hes letely filled in by the funeral director, page 2 letely filled Certification: To Be Compedical Certification:	3 ☐ Suicida 6 🏻 Could i 4 ☐ Homicida datarm	not be ined 28a. Placa o building	I Injury - At homa, fa , atc. (Specify) RESIDENCE		at, factory, office		28f. Location (St City or Town APT. 5, G			Route Number, DERLAND WAY	
	Hospita 24 hours Funere lietely fille		g Physician: To the be Examinar: On the bas and manna	est of my knowledge is of axamination ar	a, daath o	occurred at tha t astigation, in my	tima, data and place opinion, daath occu	, and dua to tha ca	usa(s) and ma	nnar as st	ated. tha causa(s)	

Medical

31. Data filad (Mon

29b. Signatura and titla of certifiar

29c. Licansa number O.C.M.E. 29d. Data signad (Month, Day, Year) MARCH 19, 1999

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #28c, per Phy. State of Maryland / Department of Health and Mental Hygiene 3/18/99, Carroll County, wjl Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician /Medical De) 1999 11:10PM March Elizabeth Maude 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Frederick Northampton Manor Nursing Home Frederick if Under 24 Hrs. 8. Date of Birth Feb. 20, 1907 if Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funderal Months Deys 1 M 2 X F Hours Maryland Dinector 218-01-8547 Usual Residence of Decedent 10d. inside City Limits 10e Stete 10b. County 10c. City. Town or Location 28s-f show 7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Maryland Frederick Brunswick Directo 8 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 126 W. Orndorff Dr. 21716 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death, we Department of Health and Merital Hygines and important: If Kern 27 Is marked other than "natural", or thems 23a, any injury or other traumatic event, the Medical Examine mail to Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Status Bleck, White, etc. 1 □ Never Married 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: Specity: þ White 3 M Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) seamstress sewing factory 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) Lola Strawburg Clabaugh Maurice 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Name/Reletionship (Type, Print) Charles F. Rentzel/ son 126 W. Orndorff Dr. Brunswick, MD 21716 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 3/18/99 nr. Linwood, MD Pipe Creek Cemetery 4 ☐ Donetion 5 ☐ Other (Specity) 22. Name end Address of Fecility
Hartzler Funeral Home 21. Signature of Funeral Service Licensee any is ar Union Bridge, MD 21791 6 E. Broadway 23e. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner es e consequence ot): Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence ot): pue attending physician for use es the buriel Box 68760. Physician/Medical Due to (or as e consequence of): 80 signed by the a d be deteched f P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 2D No 3 Probably 4 Unknown 1 Yes Division of Vital Records, þ 24b. Were eutopsy tindings eveileble prior to 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? page 2 certificate has 2 XNO 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Wes case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Certification: After 5 Pending Naturel 1 Yes death. investigation e Hospital or Attendi 24 hours after death Funeral Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 ☐ Homicide filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 16675 Wayne Allgamer 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 21716 PMNSWICK 610

State

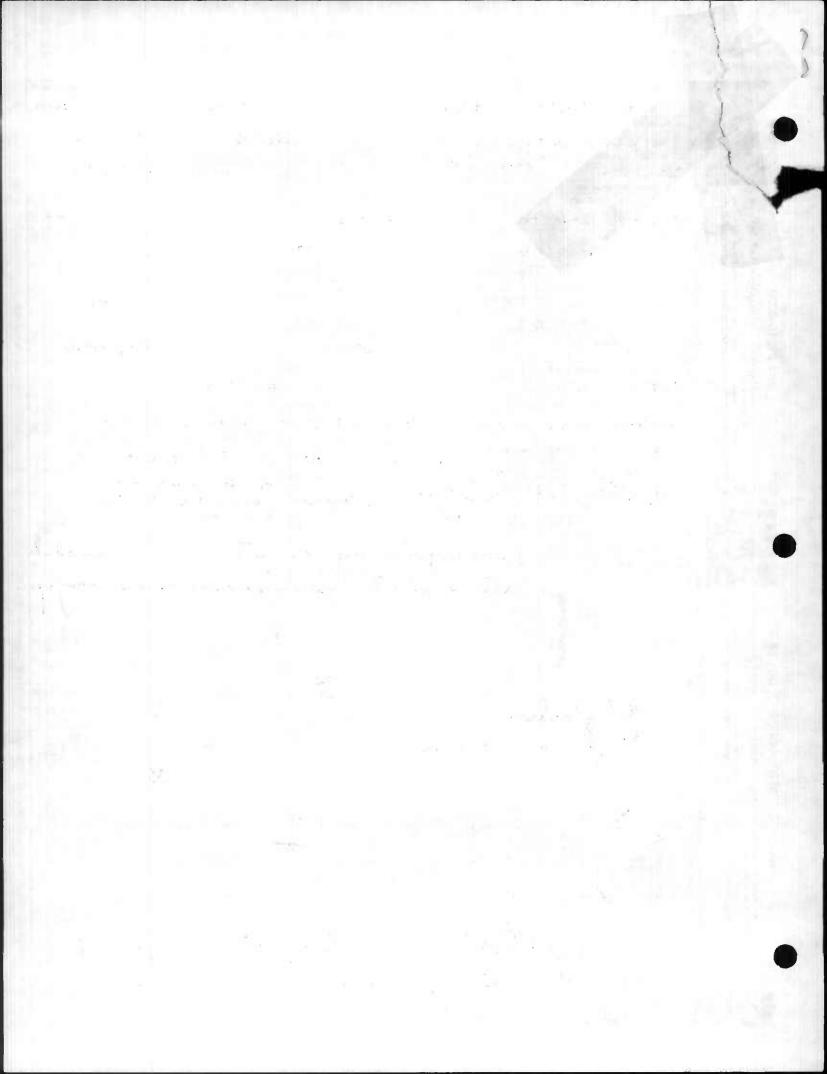
Registrar

31. Dete tiled (Month, Dey, Year)

MAR 1 8 1999

32. Registrer's Signature

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month William Henry Russell Sr. March 30,1999 1:20 AM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth 36780 Manor Road Chaptico St. Mary's If Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Months Days Hours 1 DMM 2□ F 78 Yrs. 577-28-0983 June 16,1920 Maryland Usuai Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits Maryland St. Mary's Chaptico 1 Yes 2 No 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 36780 Manor Road U.S.A. 20621 12. Wes Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □XYas 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) State Highway Admin. Truck Driver 7th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Joseph Daniel Russell Rose Ann Morgan 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Doris Russell/Wife 36780 Manor Road, Chaptico, MD 20621 20b. Placa of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4/1/99 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signatine of Funeral Service Lie 22. Name and Addrass of Fecility Mattingley-Gardiner Funeral Home, P.A. Michael tardener P.O. Box 270, Leonardtown, MD 20650 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory shock, or haart failura. List only one cause on each line. Approximate Interval Between Onset end Death Failure thorive. mouth immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequenca of): Multiple Dua to (or es a consaquence of): palein Chrowc aloc Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Physician /Medical Examiner

physician

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certificate

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Physician

/Medical

Examiner

10a State

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Funeral

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Completed

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the Meryland

death

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Heelih and Mentel hygiene. Important: If flem 27 is marked other than "natural", or haveny injury or other trainment.

Saltimore, Maryland 21215-0020

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requires that the death cartificete be exec

P.O. Box 68760

Division of Vital Records.

Examiner Physician/Medical þ Completed Be 10 Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Wera autopsy findings evelleble prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 T Yes 2 No

25. Was case referred to medical examinar? 1 Yes 2 No 27. Manner of Death

28a. Data of Injury (Month, Day Year) 5 Pending investigation

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata)

29a. Certifier 29b. Signature and title of cartifier

1. Natural

2 Accident

3 Suicide

4 Homicide

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29c. License number

6 Could not be datarmined

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29d. Date signed (Month, Dey, Year)

30. Name and addrass of parson who completed cause of death (Itam 23a) (Type, Print)

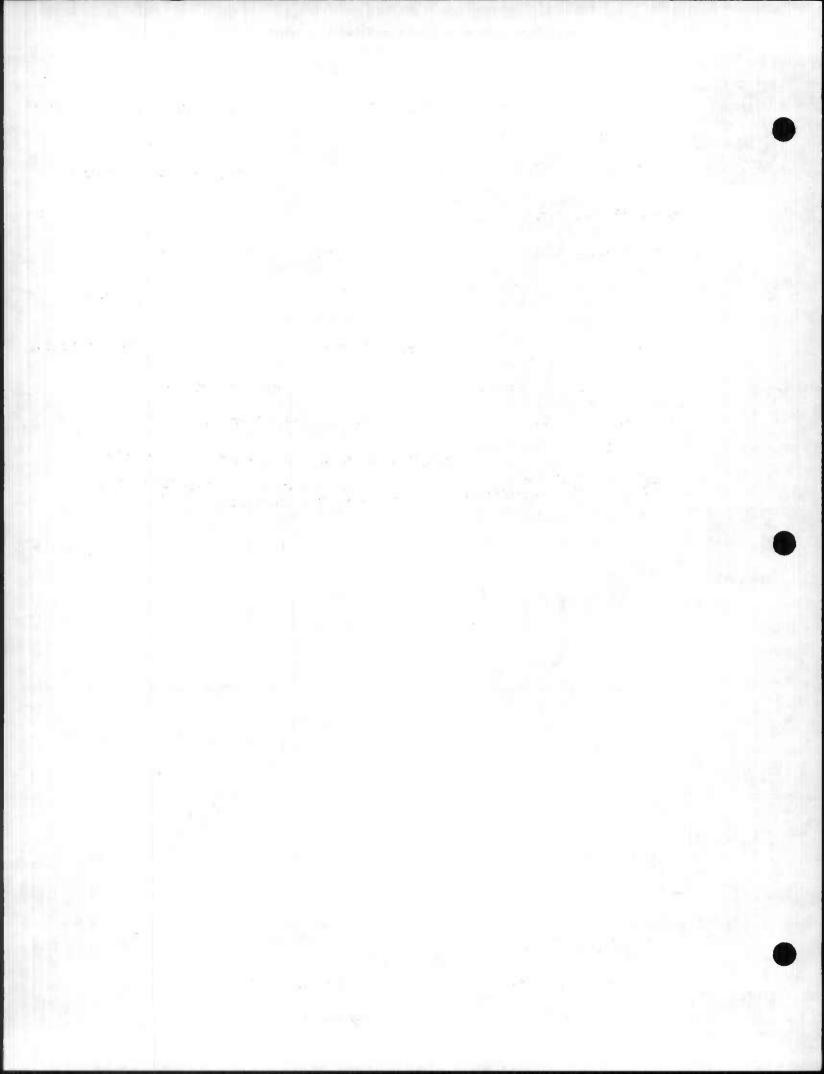
Avani D. Shah MD 31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

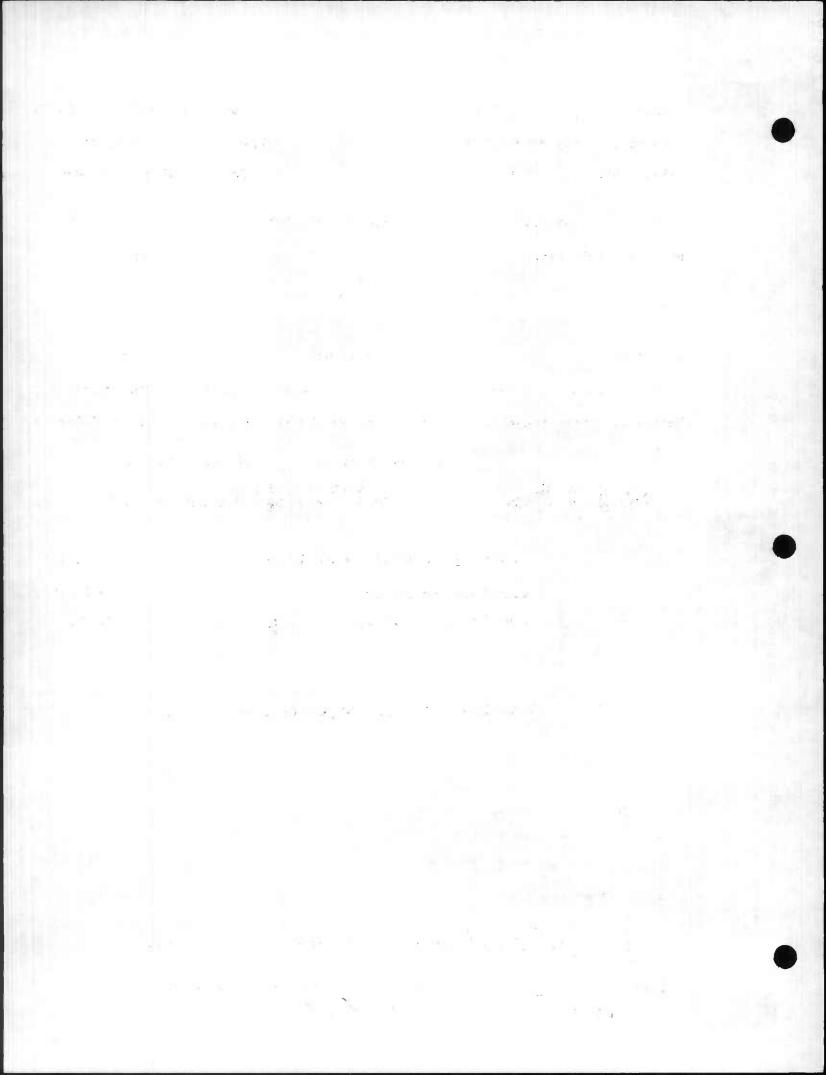
Leonardtown, MD 20650

State Registrar

edical



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								Month	Day	Year	
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Usual Residence of Decede	ent		09					JCL. 27	, 1929	Mai	yland
10a. Stete 10b. Co			10c. Cit	ly, Town or Lo	ocation					1	Od. Inside City Limits
MD	Garre	att		Mo	untain	Lake P	ark				1 X Yes 2 □ No
10e. Street end Number	Oulle			110	10f. Zip Cod		a r		10g. Citizen of V	What Cour	ntry?
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1 Never Married 2 □ 3 N Widowed 4 □ Dive		Armed Forces 1 ☐ Yes 2 K If Yes, Give Year or Dates) No		Was Decedent It Yes, specify C 1 ☐ Yes 2 💢			licen, etc.)	Specify	ck, White,	
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8th	12)	College (1-40)	· 57)		Housev	rife			Н	ome	
17. Father's Name (First, Mi	iddle, Last)			1111			er's Neme	(First, Middle,	Meiden Suman	ne)	
John Loui	is	Niner				Ann	a	Agnes	Wi	nebre	enner
19a. Informant's Name/Rela				19b. Malli	ng Address (Str				r, City or Town,		
Martha J. Lay	yton/I	aughter		P.O.	Box 394	, Terr	a Alt	a, Wes	t Virgi	nia	26764
20a. Method of Disposition			20b. F		osition (Name o			Date	20c. Location -		own, Slete
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month Day MARCH 21, RHODA BESSIE ROOT 1999 10:00 PM /Medical 4a. Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CUPPETT & WEEKS NURSING HOME OAKLAND GARRETT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (Stata or Foreign Days Hours 1 M 2 X F 1924 WEST VIRGINIA Yrs. 213-20-4962 74 Director Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director ST. GEORGE 1 ☐ Yes 2XX No TUCKER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26287 ROUTE 2 USA LIMESTONE ROAD Funeral Itams 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours efter 1 Never Married 2 Married 0. 1 ☐ Yes 2 ☒ No Specify: þ Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 traumatic event. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic eventable. 18. Mother's Name (First, Middle, Maiden Surnama) Be ARTHUR MOATS LILLIE PEARL WAGNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Numbar or Rural Routa Number, City or Town, State, Zip Coda) SHIRLEY LIPSCOMB - NIECE P.O. BOX 34 EGLON, WV 26716-0034 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State FAIRVIEW CEMETERY ST. GEORGE, WV 4 ☐ Donation 5 ☐ Other (Spacify) Funeral Service Licer 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final pneumonia weeks disease or condition resulting in death) Examiner Due to (or as a consequence of): respiratory failure years The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): ed by the ettending physician detached for use as the bune Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1- Yee 2 No 3 Probably 4 Unknown high blood pressure abdominal aneurysm þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hypothyroid certificate hes pege peripheral vascular disease 1 Yes 2 110 or Attending Physician: Be 25. Wes case referred to medical 26. Piace of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 22 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1-BNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death the 3 Suicide 6 Could not be determined 5 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours a

To the Funeral C Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier pletely (Check only one) 29b. Signature and title of detitler 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrsss of person who completed cause of death (item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth St Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 23 1999

DHMH 16 Bay 6/95

Registrar

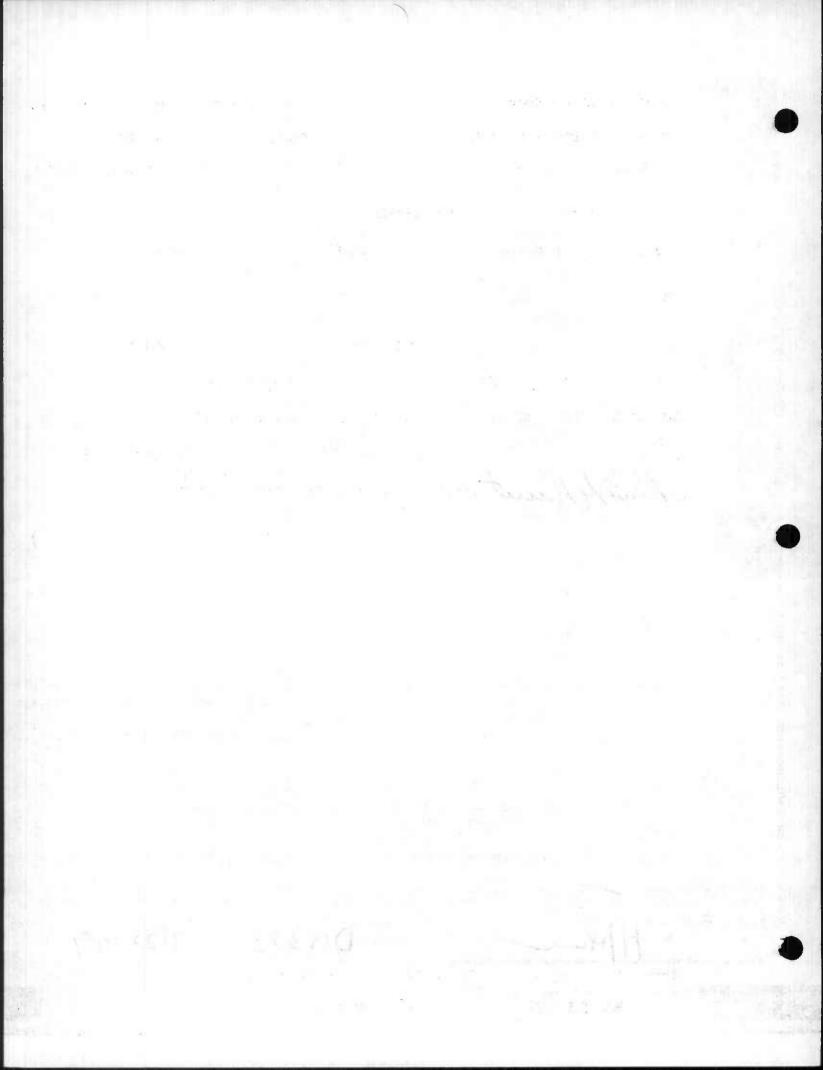
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Baltimore, Maryland

Box 68760.

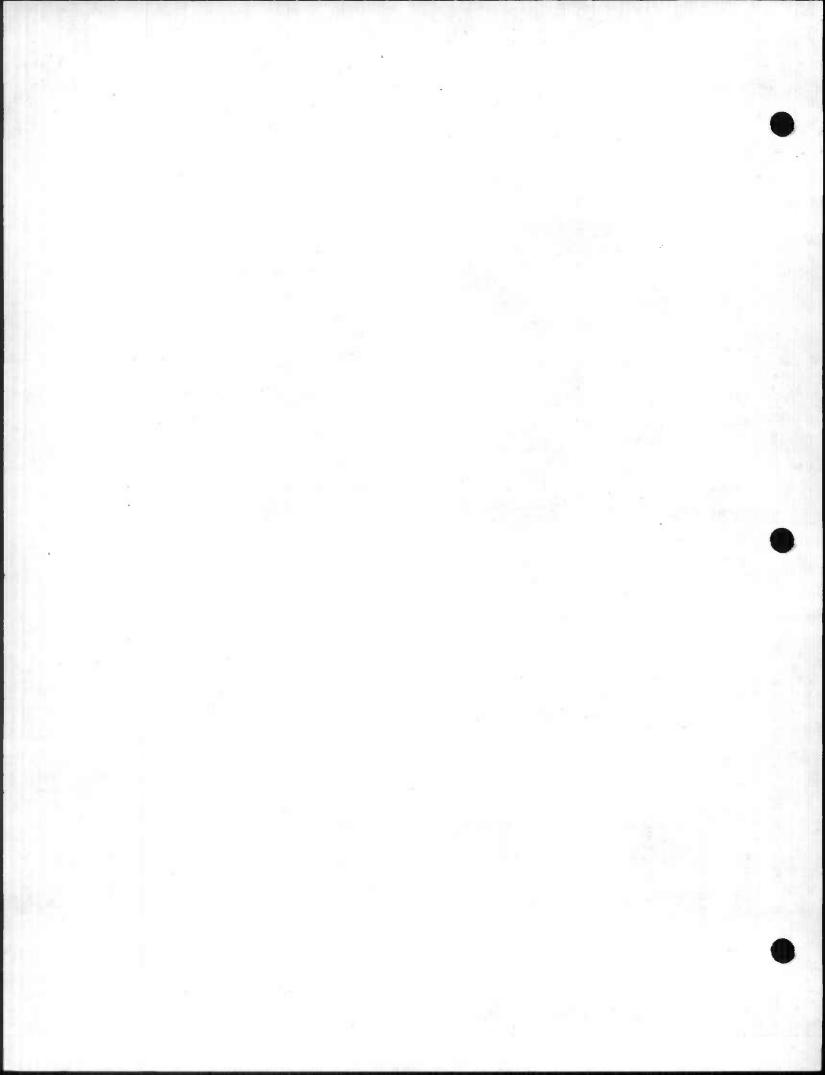
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Division of Vital Records.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_	1. Decedent's Nama (First, Middle, Last)	Reg. No. 3. Tima of Death
Physician	1 Anno	Month Day Year
/Medical	de Carità Name (Mant Institution of a standard number)	March 21, 1999 11:45 PM
Examiner	Salisbury Center: Genesis ElderCare Salisbur	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Year If Undar 24 F	
Director	214-46-2610 1 M 250 F 85 Yrs. Months Days Hours M Usual Rasidence of Decedent	lin. (Month, Day, Year) Country) February 24,1914 Maryland
Auryand I show ad at	10a. Stata 10b. County 10c. City, Town or Location Maryland Wicomico Salisbury	10d. Inside City Limits 1 ☑ Yas 2 □ No
vift the Ma t or 28a-f s be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
		USA
d 2 should be filed within 72 hours after death vin and Mental Hygene, in and Mental Hygene, or insurance event, the Medical Examiner must To Re Commissed by Funaval	3 ☐ Widowed 4 ☐ Divorced If Yas, Giva Year or Dates:	2 (Specify Yes or No- verto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. Specify: White
72 ho nathur disal	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Businass/Industry
ad within 72 ho yglene. wer than "naturn 4, the Medical.]	(Specify only highast grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) (Giva kind of work dona during most of villa. DO NOT use retired)	
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d be for the server of the ser	ă i	
d Men d Men marks marks		nie Phippin - Rural Route Number, City or Town, State, Zip Code)
d 2 a		
Tasa) Sm 2 Sm 2	20a Mathod of Disposition 20b, Place of Disposition (Nama of	Delmar, MD 21875 Date 20c. Location - City or Town, Stata
Pages natt of any or o	1 D Burial 2 □ Cremation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Parsons Cemetery	3/26/99 Salisbury, MD
Depart Depart Imports any inj	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral 501 Snow Hill Rd	Home Professional Association , Salisbury, MD 21804
/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death) a. Allor of Caraltee Caralte	WISCUIS COMO OFFEE
ficate be executed 9 physician and is the bural-transit edical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of):	
at the death certing by the attending etached for use a Physician/M	d	
the a deg	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
es that the igned by the be detached		1 Yes 22 No 3 Probably 4 Unknow
been s should		24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of cause of death?
The lay ate has page 2		1 Yes 25 No 1 Yes 25 No
certificate rector, pag	25. Wes casa rafarrad to medical 26. Place of	Death (Check only one)
Physician: this certific ral director, TO Be	axaminar? 1 Yas 2 No	g Home 5 ☐ Residence 6 ☐ Other (Specify)
ding Phys. h. After this funeral d	27. Mennar of Death 28a. Data of Injury 1 Natural 5 Panding (Month, Day Year) 28b. Tima of Work? 1 Natural 5 Panding invastigation 4 Natural 5 Panding (Month, Day Year) 4 Natural 5 Panding (Month, Day Year) 5 Natural 7 Panding (Month, Day Year) 6 Natural 7 Panding (Month, Day Year) 7 Natural 7 Panding (Month, Day Year)	28d. Describe how injury occurred
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (3 Suicida 6 Could not be determined 4 Homicida 6 Could not be determined 28a Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)
the Hospital hin 24 hours the Funeral hpletely filled	29a. Certifier (Check only one) 29a. Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place of the control of the c	aca, and dua to tha causa(s) and mannar as stated. ccurred at tha time, data and place, and due to tha causa(s)
within To the compl		29d. Data signed (Month, Day, Year)
P 5 P 0	1 / Mis- Dass	3 3/22/90
,	30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)	2/00/07
5		
Circ	Michael R. Atkins, M.D. 1104 Healthway Dr. Salisbu 31. Data filed (Month, Day, Year) 32. Bagistrar's Signatura	ry, MD 21804
State Registrar	MAD 0 4 1000	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		me (First, Middle, L				tificate of		2. Date of Deat Month	h Day	Year 0556	Deeth	
hysician /Medical		M. Small						MARCH]		9	AM	
Examiner	4a Facility Name HOLY CR	(If not Institution, g OSS HOSP	ive street end numb	ber)			4b. City, Town, or Lo SILVER SP		4c. County MONT	of Death GOMERY		
uneral rector	5. Social Security 217-53-		Sex 7	. Age (In yrs.	lest birthday) Yrs.	Months Deys 3 21	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Nov. 26		9. Birthplace (State of Country) Washington		
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red at	MD	Montgom	ery	Silv	ver Spi	ring				MXYes	2□No	
23a or 28a-f ust be roof ral Directo	10e. Street and Nu	umber				10f. Zip Code		10g. Citizen of What Country?				
23a	9737 Mt	t. Pisgah	Rd., #10	013		20703	3		United	States of	Amer	
item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director		rried 2 Married	12. Was Deced Armed Force 1 Yes 2 If Yes, Give Yeer or Date	es? (No		Vas Decedent of I f Yes, specify Cub I ☐ Yes 2€ No	Hispenic Origin? (Spien, Mexican, Puerto Specify:	(Specify Yes or Noerto Rican, etc.) 14. Race - Americ Bleck, White, Specify: B1.				
ner then "naturel", rt, the Medical Exe Completed by		15. Decedent's I	rede completed)		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retire	pation during most of works d)	ing	16b. Kind of Bu	usiness/Industry		
marked other than imatic event, the M To Be Comp	Elementary/Sec N/A		College (1-4	lor 5+)		one				I/A		
Be se		(First, Middle, Les B. Martin					18. Mother's Name	y Small:		10)		
To		Name/Relationship			19b. Mailin	Q Address (Street	end Number or Run			Stete, Zip Code)		
r trau		y Smalls	mother				o, c, e, f		,			
ry or othe	20e. Method of Dis	sposition	□Removal from St	ate	Plece of Disposemetery, crem	sition (Neme of netory or other ple Nationa)	ce)			City or Town, State		
Important: if Item 27 any injury or other to once.	21. Signatura of 5	uneral Service Lice	ensee	ie)	,	Name and Address	St., NE W			Company, In 20017	ic.	
physicien end s the buriel-transit s the buriel-transit edical Examiner	Immediate Cause disease or condition resulting In death) Sequentially list confidence if any, leeding to it cause. Enter Unicause, Classase of that initieted event resulting in death)	onditions, mmediate lerlying r injury	a	Due to (o	DEN INFA or as a consequence a consequence as a consequen	uence of):	SYNDROME					
0 0	resulting in death)	Last	d							i		
deteched for use	Part II. Other signi	ificant conditions	contributing to dea	th but not resi	ulting in the ur	nderlying cause gi	ven in Part 1.	23b. Did to	bacco use co	ntribute to the cause	of death?	
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should								24a. Was e perform		24b. Were autopsy evelleble prior completion of of of death?	to	
rector, page 2								184	s 2 No	1 ☐ Yes 2 ☐	No	
Be (25. Was case refe examiner?		Magaite!:				26. Piece of Deat	h (Check only on	e)			
ral dire	27. Manner of Dea		Hospital: 1 Inp		ER/Outpatien 28b. Time of	T 3LI DOA		me 5 Reside				
Certification:	1 Netural 2 Accident 3 Suicide	5 Pending investigati	(Month,	Dey Year)	Injury	M 1	Yes 2□No					
	4 Homicide	determine	d 280. Place o	f Injury - At ho , etc. (Specif)		eet, factory, office		28f. Location (St City or Town	, Stete)	per or Rural Route Num	iber,	
od in by								end due to the ca	ause(s) and ma	anner as steted. and due to the cause(s	s)	
e Funeral Direction by the filled in by dical Certif	29e. Certifier (Check only one)	1☐ Certifying P	eminer: On the bes and manne									
To the Funeral Director: After this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only one)	2 Medical Exa	aminer: On the bes	r steled.		29c. Licens	se number	2	9d. Dete signe	d (Month, Day, Year)		

Marin Table Committee on Self-

State of Maryland / Department of Health and Mental Hygiene O

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al or	5. Social Security N 052-36-4	468	1 M 2 XF	7. Age (In yrs 54	Yrs	Months		Hours	Min.	MAY 26	1944	NEW NEW	plece (Stete or Foreign YORK
	Usuel Residence o	10b. County		10c. C	ity. Town or	Location						1	IOd. Inside City Limits
rector	MD		GEORGES		*	VILLE,	MD						XIX Yes 2 □ No
Director	10e. Street and Nu		GEUNGES	F	OKESI	-	p Code				10g. Citizen of	Whet Cour	ntry?
		OKS DRIVI	E APT 10	5				747		UNITED			•
by Funeral	11, Marital Status	ried 2K) Married	12. Wes Dece Armed For 1 Yes If Yes, Giv Yeer or De	dent Ever in trees?	U,S. 1	3. Wes Dece If Yes, spe				pecify Yes or No Rican, etc.)	14. Rec Bla Specifi	ck, White,	can Indien, etc. ACK
		15. Decedent's E	ducation		16e. De	cedent's Usu	el Occur	pation			16b. Kind of B	usiness/în	dustry
Completed	Elementary/Seco	olly only highest gr ondary (0-12)	College_(1	-4or 5+)		icedent's Usu ive kind of we e. DO NOT u MEMAKE		during mos od)	it of work	king	PRI	VATE	
To Be	The second second second	HOMEMAKER PRIVATE HOMEMAKER Father's Name (First, Middle, Last) ELIJAH WILLIAMS HOMEMAKER 18. Mother's Name (First, Middle, Meiden Surneme) MINNIE SMITH											
	AND SOUTH	9a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stet											Code)
		Fa. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Ste 2021 BROOKS DR. APT 105 FORESTVILLE, N											
		Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City											
	4 ☐ Donation	TEMBURIAL 2 Cremation 3 Chemoval from State A Condition 5 Context (Specify) MD. VETERANS CEMETERY 3-19-99 CHELTE											
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n I	Immediate Ceuse disease or condition	non		ech line.	etn. Do not	enter the mo	de or dy	ng, such es	cardiac	or respiretory e	rrest,	† † † - -	Approximete Intervel Between Onset end Deeth 48 HOURS
_	resulting in deeth)			Due to	(or es e con	sequence of)):						
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To	1 ☐ Yes 2 🖺			npatient 2[☐ ER/Outpe		OA		ursing H		Idence 6 Ott		(fy)
sation:	27. Manner of Deer	5 Pending investigation	n	of Injury h, Dey Year)	28b. Tim- Injui	e of ry M	28c. Inju Wo 1 [ryet ork?]Yes 2 □	No	28d. Describe	how injury occur	red	
Certification:	3 ☐ Suicide 4 ☐ Homlcide	6 Could not be determined	28e. Pleca buildir	of Injury - At I	home, ferm, ify)	street, facto	street, factory, office 28f. Location (Street end Number or Rural Route City or Town, State)			al Route Number,			
edicai	29a. Certifier (Check only one)	1 ★ Certifying Pt 2 ■ Madical Exa		isis of examin									
Σ	29b. Signeture end	title of certifier				29	c. Licens	se number			29d. Dete signe	d (Month.	Dev. Year)

State Registrar

31. Date filed (Month, Dey, Year)

MAR 1 6 1999

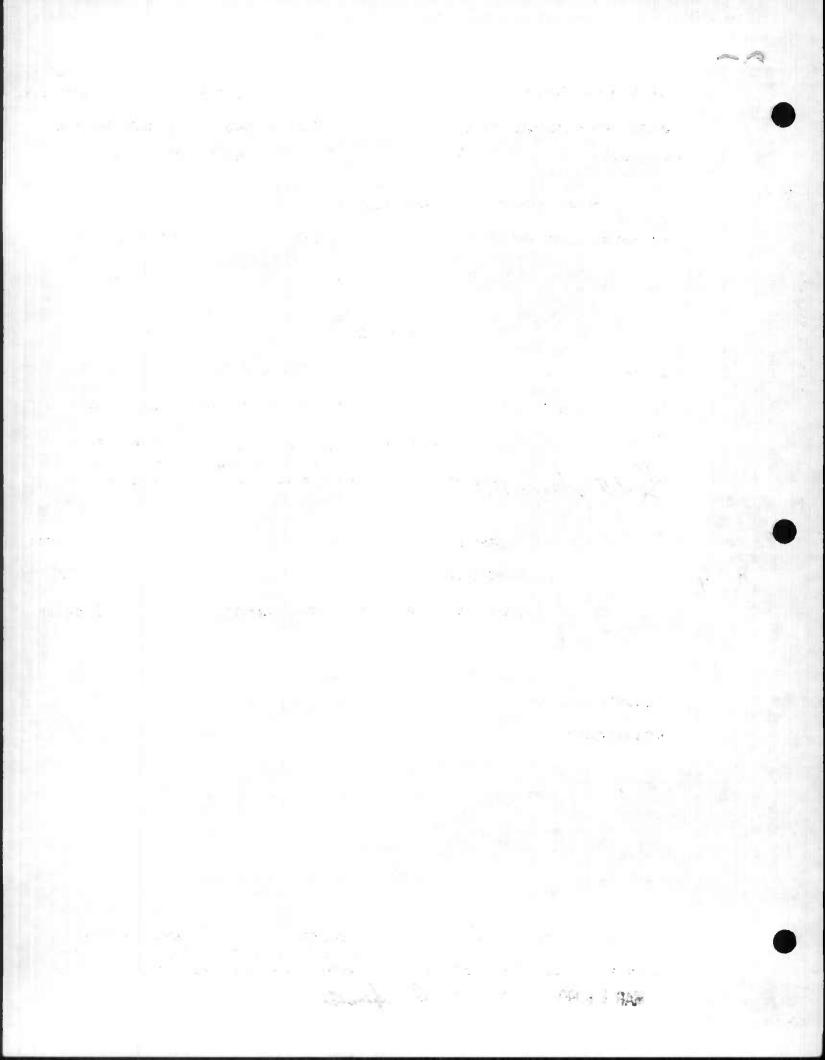
SHARON R. OBRIEN, MAJ, USAF, MC 2. Registrer's Signature ANDREWS AIR FORCE BASE, MD. 20762-6600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 89 MDG/1050 W. PERIMETER RD. SUITE C1-7

D52353

MARCH 10 1999

SIMMONS, BARBARA A



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wilbert Newton Sales 8, March 1999 11:59 pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F Months Days Hours Min. Yrs. 82 Virginia 577-03-8295 Aug. 18, 1916 Director Usual Residence of Decedent the Marylend 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4321 Clagett Road 20782 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental thygiene.
Int: if item 27 is marked other than "natural", or healtry or other traumatic event, the Medical Example. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Manager Soft Drink Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Robert Lewis Sale, Jr. Susie Lee Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Holden Sales 43 Cheerywood Court, Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or George Washington Cemetery 03/12/99 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) invine (D 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21/Signature of Funda 4739 Baltimore Avenue, Hyattsville, MD 20781 Dus complications that caused the dis-Approximate Interval Between Onset and Death Part I. Enter the disease, of shock, or heart failure. List Do not enter the mode of dying, such as cerdiac or respiratory arrest, Physician /Medical Immediate Cause (Final Cardia polmonary Arrest disease or condition resulting in death) **Examiner** Examiner Atherosclerofic ician and buriel-trans Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificata be axec physician Physician/Medical the Due to (or as a consequence of) 98 ettending usa or Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy completion of ceuse of death? pege 2 has 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: 24 hours aftar death. Funeral Diractor: Atter this certific funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 - Homicide 24 hours 6 • Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical ompletaly To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TOORIT 99 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year) MAR 1 5 1999

TERRY JOORIE) MD

PRINCE GEORGES HOSPITAL COUTER I CHEVERLY, MAKMIAND 32 Registrar's Signature

Baltimore, Maryland 21215-0020

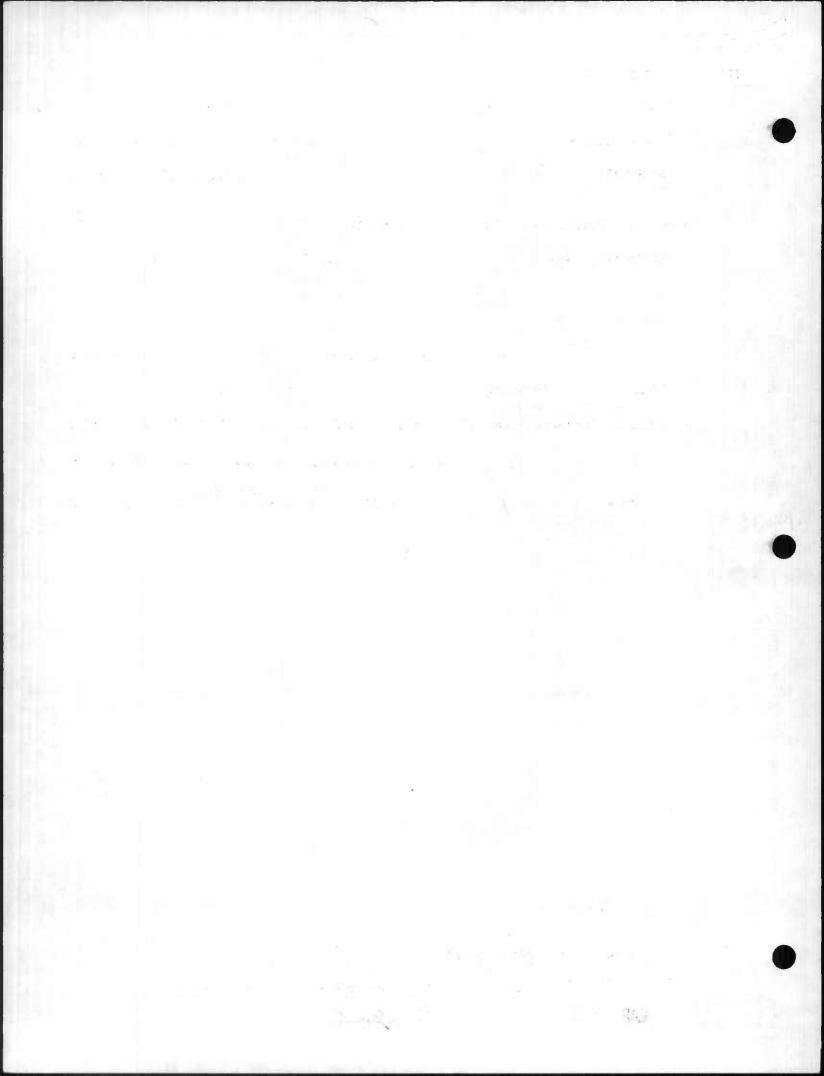
Box 68760.

P.O.

Division of Vital Records,

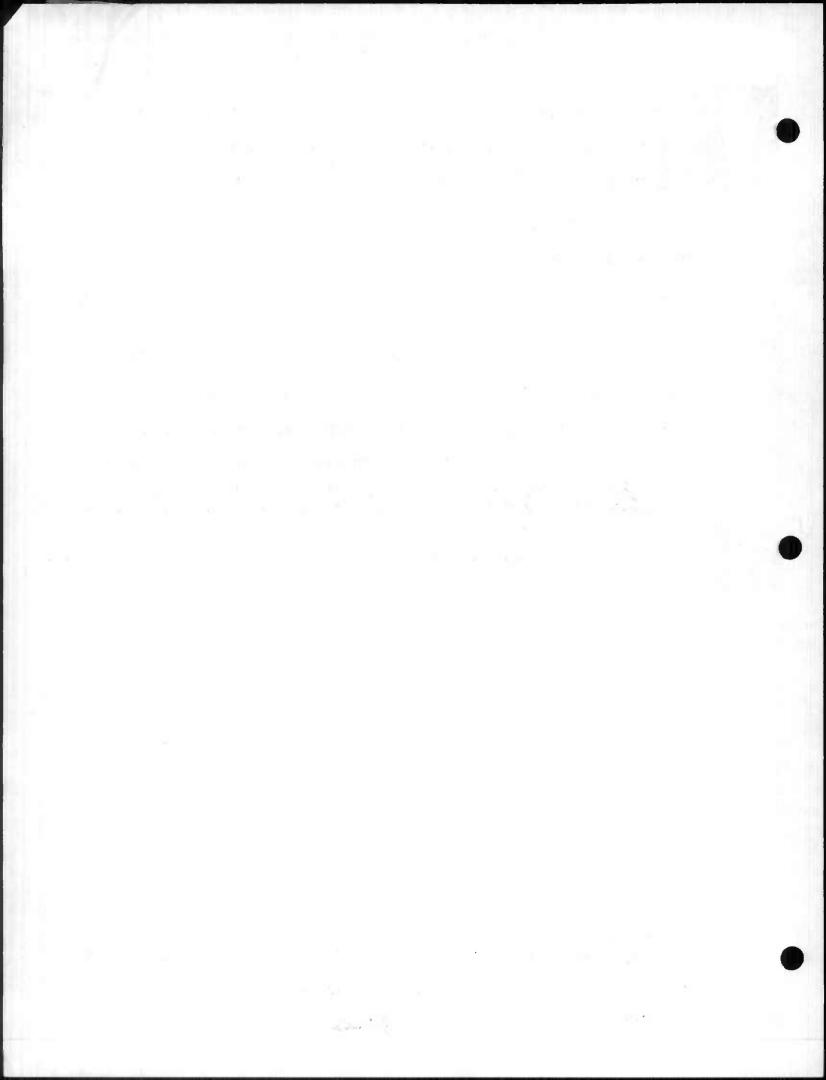
and the second to the Min

	23 PART I, 27 PER MEO G 1. Decedent's Neme (First, Middle, Last		****				2. Dete of Deet Month	h Dev	Yeer	3. Time of Deeth
in al	Marc Sch	lossberg					MARCH	15, 199		1915 PM
er	4e Fecility Neme (If not institution, give	street and number)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
	22 WOODLAND WAY			Killad	er 1 Year	GREENBELT		PRINCI		
	218-98-5339	X M 2□F	e (In yrs. last b	Yrs. Months		Hours Min.	8. Dete of Birth (Month, Dey, Sept. 1			ece (State or Fore y) cyland
ŀ	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Tov	vn or Location					10	d. Inside City Lim
	Maryland Prince G	eorge's	(reenbel	t					1 N Yes 2 □ N
1	10e. Street end Number	COLSO D		- 1	ip Code		1	0g. Citizen of W	hat Countr	ry?
1	22 Woodland Way				20	0770		U.S.A		
	11. Maritel Status 1 💢 Never Married 2 🗆 Merried 3 🗆 Widowed 4 🗆 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 H Yes, Give Yeer or Detes:		13. Was Dec If Yes, sp		dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e	tc.
	15. Decedent's Edu	ucation	166	Decedent's Us	suel Occur	pation		16b. Kind of Bu		
	(Specify only highest gred	College (1-4or	5+)	life. DO NOT		pation during most of work d)	ang	Music	Indu	ıstry
	17. Fether's Neme (First, Middle, Last)					18. Mother's Nam	e)			
	Robert Schl	ossberg				Mona				
	19a. informent's Neme/Reletionship (7)					t and Number or Ru				
	Robert Schlossber	g - Fathe				Hill Driv	-			
I	20e. Method of Disposition 1 ☐ Buriel 2 【XCremetion 3 ☐ F	Removel from State	cemete	of Disposition (N ary, cremetory or	r other ple			20c. Location -		
	4 ☐ Donetion 5 ☐ Other (Specify)	00	Metro	politan			03/17/99	Alexand	ria,	Virginia
	21. Signature of Funeral Service/Libens	1 /				ess of Fecility uneral Ho	me. P.A.			
1	Henry &	tark		4739	Balt:	imore Ave	nue, Hya			
	23a. Part1. Enter the disease, or compi shock, or heek failure. List only o	iications that cause ne ceuse on eech li	d the deeth. Do ne.	not enter the m	ode of dyi	ng, such es cardiac	or respiretory err	est,		Approximete Intervel Between Onset end Deeth
	Immediete Ceuse (Final								1	Onset ond Deeti
	diseese or condition resulting in death)	е	PNEUMO		114	τ				
l			Due to (or es e	consequence o	f):				1	
ı		b	Due to (or es e	consequence o	٨٠					
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury		000 10 101 03 0	0011304001100 0	• /-				1	
	that initiated events	C	Due to (or es e	consequence of	f):					
	resulting in death) Lest								į	
		d								
ĺ	Pert II. Other significant conditions con	ntributing to death b	ut not resulting	in the underlying	g cause gi	ven in Pert I.	23b. Did to	bacco use cor	tribute to	the cause of dea
							1 🗆 Y	es 2 No	3 Prob	ably 400nkn
							24e. Wes e	n eutopsy med?	eve	re eutopsy finding ileble prior to apletion of cause leeth?
							h	2 □ No	Q	Yes 2□ No
	25. Wes case referred to medical					26. Plece of Dee	th (Check only or		-	
	exeminer?	Hospital: 1 ☐ inpati	ent 2 ER/C	Outpetient 3 1	DOA OI	hor	ome XX Reside		er (Specify)
To B	27. Menner of Deeth 1 X Naturel 5 Pending 2 Accident investigation	28e. Dete of inju (Month, Da		Time of Injury	28c. Inju Wo		28d. Describe ho			
	3 Suicide 6 Could not be 4 Homicide determined	286. Pieca of in	jury - At home, to. (Specify)	farm, street, fact	ory, office		28f. Location (Si City or Town		er or Rurei	Route Number,
	29a. Certifier (Check only) Check only C									
	(Check only 2 Medicai Exami	iner: On the basis of								
	(Check only 2 Medicai Exami	iner: On the basis of	eted.	≥ 29b. Signature and title of certifier 29c. License numb						
	(Check only 2 Madical Exami	iner: On the basis of	eted.	2	OCME			9d. Dete signed MARCH 1		
	(Check only 2 Medical Examinate) 290. Signature and title of certifier	iner: On the basis of end menner st	0							
1000	(Check only 2 Medical Examinate) 290. Signature and title of certifier	iner: On the basis of end menner st	eted. deeth (Item 23e)) (Type, Print)	OCME		1	MARCH 1	6, 19	99



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physici /Medi	ical EFFAT SAADATMAND										Day 15,199		3. Time of Death 12:40pm
	Examir Funeral Director	ner	The state of the state of	Grove Ad Number 6.3	ventist		st birthday)	If Under 1 Ye Months De	Rocks	ille	MD Date of Bi	Mont	gome	place (State or Foreign
	yland		10a. State	10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	death with the Meryland ms 23a or 28a-f show	Funeral Director	MD	MONTGOM	ERY	POTO	MAC							1X Yes 2 No
	with th	Dire	10e. Street and N					10f. Zip Cod				10g. Citizen of	What Cour	ntry?
	eath w	erai	11. Marital Status	KERMAN LA	12 Was Decedon	t Ever in U.S.	13 V		864 of Hispanic Ori	inin? (Specil	v Yes or N	IRAN	ce - Americ	an Indien.
020	72 hours efter dea natural', or flems iteal Examiner m	by	1 Never Ma	rried 2 Married	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No		Vas Decedent of Yes, specify C			can, etc.)		cack, White, etc.	
5-0	"natural",	eted	(Spe	15. Decedent's E	ducetion ade completed)		16e. Deced	lent's Usuel Ockind of work do	cupetion	et of working		16b. Kind of B	usiness/în	dustry
21215-0020	filed within Hygiane. Ither than "	Completed	Elementary/Sec	ondary (0-12)	College (1-4or	5+)	TEACH	OO NOT use ret	ired)			SCHO		
Maryland	should be filed within and Mantal Hygiane. marked other than umatic event, tra M	To Be	ALI MOHAMMAD SAADATMAND SADGHA 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or N									e, Maiden Surnar MAND	ne)	
	1 and 2 and 4 and 2 and 4 and		19e. Informant'a Name/Relationship (Type, Print) PARVIZ MOKHTARI / SON 8904 TUCKERMAN LANE, POTOMAC, MD 20854 20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State, Date 20c, Location - C								54			
imo	Pag nant unt: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place) ESSAHAN CEMETERY 3-									,		
Baltimore,	permit. Pag Depertment Important: I any injury o		20e. Method of Disposition Date Date 20c. Location - City or cemetery, crematory or other place)											
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or completation at caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cate of each line. Immediate Cause (Final disease or condition resulting in death) e. OVARIAN CANCER Due to (or as a consequence of):									Inierval Between Onset and Death 3 MONTHS		
68760,	requires that the death certificete be executed seen signed by the attending physicien and hould be dateched for use as the buriet-transit	al Examiner	Sequentially list c if any, leading to l cause. Enter Und cause (Disease o that Initiated even	Sequentially list conditions, f any, leading to Immediate auses. Enter Underlying Cause (Disease or Injury hat initiated events. Due to (or as a consequence of): Due to (or es e consequence of):										
XO	h certificete anding phy use as the	Physiclan/Medical	resulting in deeth)	Lest	d	Due to (or e	es e consequ	uence of):						
. B	res that the death signed by the atte i be dateched for	sicla	Part II. Other sign	ificant conditions	contributing to death t	but not result	ing In the ur	iderlying ceuse	given in Part	l.	23b. Did	tobecco use co	ntribute t	o the ceuse of death?
P.O.	d by ti										1 🗆	Yes 20 No	3 Pro	bably 4 🗆 Unknow
Records,	w requires the been signed should be d	Completed by									performed? available pr			ere autopsy findings allable prior to impletion of ceuse death?
Re	The law rate hes by page 2 st	оше									1 🗆	Yes 2X No	150	☐ Yes 2☐ No
of Vital	yslcian: The s certificata director, pag	Bec	25. Was case refe examiner?	erred to medical					26. Place	e of Death (0	Check only	one)		
7 \	0 0	To	1 ☐ Yes 2 🖸		Hospital: 1X Inpati		R/Outpatien	3LI DOA		ursing Home	5 ☐ Res	idence 6 □Ott	ner (Specil	(y)
Division o	ing ing	Certification:	27. Manner of Dee 1 ⊠ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investigatio			8b. Time of Injury	M 1	njury at Vork? Yes 2	No		how injury occur		
Div	ital or Attendius eftar deathrai Director: A		4 Homicide	dataminad		ijury - At hom tc. <i>(Specify)</i>	ie, farm, stre	et, factory, offi	De	281	City or To	(Street and Numi wn, State)	ber or Run	al Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.							nd place, end ath occurred	due to the at the time,	, date and place,	and due to	the ceuse(s)
	N Vit	Σ	296. Signature an	O title of conflict	18	10	`		ense number			29d. Date signe		
	(3)		30. Name and add		completed cause of			Print)	37024			MARCH	15,	1999
	- 01			G. SNOUR,	M.D. 990) 1 MED : rar's Signatu	ICAL (CENTER 1	DR. ROC	CKVILL	E,MD	20850		
	Sta Registr	_	31. Date filed (Mo	R 1 7 1999	30	single of	G .	back						



ian	C		Dete of Deeth			Time of Death			
al .	24001 WIMMET C		MARCH	10		700			
er		iworship		4c. County o	30 MM	/			
	5. Social Security Number 113-56-1174 6. Sex 1 O No. 1	if Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey, NOV • 7	1921	9. Birthplace (Country)	(Stete or Foreig Egypt			
	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location				10d. In	side City Limits			
	MD Montgomery Silver Spring				1	☐ Yes 🏖 No			
	10e. Street and Number 1316 Fenwick Lane 2	20910	10	og. Citizen of WI US					
	1 Never Married 2 Married 1 Yes 2 No	ident of Hispanic Origin? (Specify Yes or Nicify Cuban, Mexican, Puerto Rican, etc.) No Specify:		Biack	- American Inc., White, etc. White				
	15. Decadent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	uring most of working	1	Jewer	JA .				
	12 Dîamond Cutt 17. Fether's Neme (First, Middle, Last) Chaim Babayof	er 18. Mother's Neme (i Unknown			**				
	•	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)							
	Leah Kedar/Daughter 7014 Woodlan	a Park	, MD	20912					
	20e. Method of Disposition **DBurial 2 © Cremation 3 © Removel from State **Donetion 5 © Other (Specify) 20b. Piece of Disposition (Neme of cametery, cremetory or other place) Cedar Park Ceme	etery 3/1		Westwo					
	21. Signature of Funeral Service Licensee 22. Name and Address Stein Heb 232 Carro	orew Memo				e 20012			
	resulting in death) Due to (or es e consequence of): b. Due to (or es e consequence of): if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of):								
	d Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given	n in Pert I.	23b. Did to	bacco uae conf	tribute to the	cause of death			
			1 🗆 Ye	es 2 No	3 Probably	Unknow			
Pe			24a. Was er perform	n eutopsy ned?	eveilable complete of deeth	1/			
			1 ☐ Ye	s 2100	1 🗆 Yes	s 280 No			
	25. Was case referred to medical	26. Place of Deeth (Check only on	e)					
	25. Was case referred to medical exeminer? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other	4 U Nursing Home	Reside	e) enca 6 Othe ow injury occurre					
000	25. Was case referred to medical exeminer? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other	et 26	e 5 Reside	enca 6 Other	bed	ute Number,			
	25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 4 Homicide 28e. Dete of Injury (Month, Dey Year) 28e. Dete of Injury (Month, Dey Year) 28e. Place of Injury - At home, farm, street, factory, offica	et 28 /es 2 No 28 e, dete end plece, en	Bd. Describe ho City or Town dd due to the ce	enca 6 Other ow injury occurre reet end Number n, Stete)	er or Rurel Rou				
Medical Certification: To Be Completed	25. Was case referred to medical exeminer? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 4 Homicide 28e. Dete of Injury (Month, Dey Year) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 29e. Certifier (Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opin end menner steted.	et 28 2 No 28 e, dete end plece, en inion, deeth occurred	e 5 Reside ed Describe ho eff. Location (Str. City or Town and due to the ce of et the time, de	reet end Number, Stete) ause(s) end mer ate and place, e	or or Rurel Rou nner es stated and due to the	ceuse(s)			

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State of Maryland / Department of Health and Mental	Hygiene

			Certifi	cate of D	eath	R	eg. No.		
ysician	1. Decedent's Name (First, Middle, La	ast)				2. Dete of Dee Month		3. Ti	me ot Death
cian Iical	William	Α.	Sprin	ger			14, 1999		00 PM
ner	4e Fecility Neme (If not institution, gir	ve street and number)		4b	. City, Town, or L	ocation of Deeth	4c. County of	Deeth	
	16010 Excalibur				Bowie			George	
ni r	5. Social Security Number 6. Social Security Number 98-22-1728 Usuel Residence of Decedent	7. Age (In)		Inder 1 Year onths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March I	2, 1919	B. Birthplece (S Country) Waverly	r, Penn.
	10a. State 10b. County	10c.	City, Town or Location	1				10d. Insi	de City Limits
Director	Maryland Prince	Georges	Bowie						Yes 2□No
al Dir	10e. Street end Number 16010 Excalibur	Rd.	10	f. Zip Code 2071 (5		0g. Citizen of Wh	et Country?	
by Funeral	11. Meritel Stelus 1 Never Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 12. Yes 2 \(\times \) No if Yes, Give Yeer or Detes:		VV	panic Orlgin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black,	American India White, etc.	en,
ted	15. Decedent's E	ducation	16e. Decedent's	Usuel Occupet	tion	king	16b. Kind of Business/Industry		
Completed	(Specify only highest gr Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)	uring most of wor	nay			
Con	Elementery/Secondary (0-12)	4	Specia	1 Educa	ation		D.C. Pub	lic Sch	nool Sys
Be	17. Fether's Neme (First, Middle, Las	1)			18. Mother's Nen	ne (First, Middle,	Meiden Sumame)		
To	Asa Springer				Carrie	Clark			
	19a. Intorment's Neme/Reletionship	(Type, Print)	19b. Meiling Ad	dress (Street a	nd Number or Ru	ral Route Numbe	r, City or Town, St	tate, Zip Code)	
	Wahnita W. Sprin	ger (Wife)	16010 I	Excalib	ır Rd. B	owie, MD	20716		
	20a. Method of Disposition	20	b. Plece of Disposition cemetery, cremator	(Name of)	Dete	20c. Location - C	ity or Town, Ste	ete
	1 Burial 2 Cremation 3 4 Donetion 5 Other (Speci		Metropolita			3/15/99	Alexandr	ia. VA	
one one	21. Signature of here! Service Lice							14, VII	
	1 d. 1.	1. 1	Re	endon/Ha	ale Fune	ral Home			
	23a. Pur1. Enter the disease, or con	Jens	90	13 Anna	apolis R	d. Lanha	m, MD 20		ximate
edicai Examiner	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last	b. Due t	to (or es e consequenc	e ot):					
Physician/Me		d							
sici	Pert II. Other algnificant conditions	contributing to death but not	resulting in the underl	ving cause give	n in Pert I.	23b. Dld to	obacco usa conti	ribute to the ca	use of death?
by Phy	C	oronary Art	ery Dise	ase		1 U Y	es 2X No	☐ Probably	4 Unknown
completed p						24e. Wes e perfor	en eutopsy med?	24b. Were auto eveileble completio of death?	opsy findings prior to n of cause
E O						1 🗆 Y	es 2000	1 ☐ Yes	2 No
D	25. Wes case reterred to medical				26. Plece of Dec	eth (Check only or	76)		
0	exeminer? 1 ☐ Yes 2 ☑ No	Hospital:	2 ☐ ER/Outpetient 3	Othe	r'	lome 5 ☑ Resid		(Specify)	
n: To	27. Menner of Deeth	28e. Date of Injury	28b. Time of	28c. Injury Work			ow injury occurred		
Certification:	1 Naturel 5 Pending investigation 3 Suicide 6 Could not 1 determined	28e. Plece of Injury - /	At home, tarm, street, t	1 1 Y	r es 2□No		treet and Number	r or Rural Route	Number,
	4 Homicide	building, etc. (Sp				City or Tow			
edical		hysician: To the best of my minar: On the basis of exan end manner stated.							iuse(s)
M	29b. Signeture end title of certifier			29c. License	number	2	29d. Dete signed	(Month, Day, Y	ear)
1	pour Evan	n mp - k	TTEH OLOG	Dle	5197		3-15-9	9	
1	30. Neme end eddress of person who					C. Lara	a, M.D.		
6	9326 Lanham-	Severn Rd.,	Lanham,	MD 20	706				
tate	31. Dete tiled (Month, Day, Year)	32. Registrer's S	igneture	_					

" BAK

			1 10000	State of N		d / Dep	artment ertificate	of H	dealth a		ental Hy	giene Reg. No.		0949	
	Physician	Decedent's Name M	a (First, Middle, La IACK	LEWIS	S	KINNE	>				2. Date of De	10,1999	Year	3. Time of Deeth 6:42 AM	
	/Medical	4a Facility Name (I				T.T.IATATAT			4h City To	wn. or Lo	cation of Deat			0112 /111	
	Examiner		ndel Hospit		91)				Elen Bu		oution or boun	Anne A			
ŀ	Funeral	5. Social Security N	-		Aga (In yrs.	est birthday)	If Under 1	Year	If Under:	24 Hrs.	8. Date of Bir (Month, Da			placa (Stata or Foraign	
	Director	238-56-24		MM 2□F	62	Yrs.	Months	Days	Hours	Min.	Sept. 2			n Carolina	
	p ,	Usual Residence of	Decedent			-						211330			
	ahov	10a. Stata	10b. County	J-1		, Town or L	ocation							0d. Insida City Limits 1☐ Yes 2☐ No	
	the M	MO. 10e. Street and Nur	Anne Arun	per	CE	ofton	10f. Zip (Code				10g. Citizen of V	What Cour		
	with with I Did		Grove Lane	9			2111					, , ,			
	72 hours after death with the Maryland natural, or items 23s or 28s-1 show also Examine must be notified at seed by Funeral Director	11. Marital Status		12. Was Decede	nt Ever in U,	S. 13.	Was Deceda	ant of H	lispanic Orl	gin? (Spe	ecity Yes or No	- 14. Rac		en Indian,	
0	or Reminer	1 Never Marri	ied 2 Married	Armed Force 1 X Yes 2[If Yes, Give				Was Decedant of Hispanic Origin? (Spe If Yas, specify Cuban, Mexicen, Puerto F 1 ☐ Yes 2 🌣 No Specify:			Hican, atc.)		ck, White,	etc.	
302	ens.	3 D Widowed		Year or Date:	s:		10165 2	22 140	Зраспу.			Specify	Bla		
21215-0020	led within 72 hours lygiene. ner than "natural", nt, the Meuleal Ex, Completed by	(Spec	15. Decedent's Ed	ducation ide com <i>pleted)</i>		(Give	dent's Usual kind of work	done	during most	of worki	ing	16b. Kind of B	usiness/In	dustry	
12	withir me.	Elementary/Seco	ondary (0-12)	College (1-40 4years	or 5+)		DO NOT use					Governm	ant		
0	be filed d other avent, u	17. Father's Name	(First, Middle, Last)			1000	d itali		1	r's Name	(First, Middle	, Maiden Sumen			
lan	should be of Mental marked o matic av	Henry L.	Skinner						Essi	e Phi	ne Coppe	r			
Maryland	d 2 should be filed th and Mental Hyg 7 Is marked other traumatic avent, To Be C	19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mail	ing Address	(Street	end Numbe	er or Rure	I Route Numb	er, City or Town,	Stete, Zip	Code)	
			Skinner/Wi	fe		2063	B Lake G	rove	e Lane,	Crof		21114			
ore	0 0 0	20a. Method of Disp	position □ Cremation 3 □	Ramoval from Sta	te Mar	lace of Disp ematary, cre	osition (Nemo ematory or oth eterans	e of her ple	ce)	3/17	Date /OO	20c. Location -			
altimore	tment tant: If	4 ☐ Donation	5 ☐ Other (Specif	y)	PEL						7 33	CELONIA	III. L'EXI	.yıaın	
Bal	permit. Pages 1 an Department of Heat Important: If Item 2 any Injury or other phcs.	21. Signature of Fu	neral Service Licer	1500		2	2. Name and	Addre	ess of Facilit	J.B	.B. Jenkins Funeral Hare				
		De	may	. Gens	Jur							ryland 20	785	Annaulmata	
	Dhusisian	shock, or hea	he disease, or form rt failure. List only	one cause on each	ine.	i. Do not en	iter the mode	or dyn	ng, such as	Cardiac C	or respiratory a	11031,		Approximate Interval Between Onset and Death	
	Physician /Medical	Immediate Ceuse ((Final	1	nua	110	0.1	in	lan	The	n. 111	To		10 hours	
	Examiner	disease or condition resulting in death)	n	θ	Due to (o	r as a conse	equence of):				n, au	· •		10 hours 6 years	
-	n and ial-transit		_	. 0	oro	non	, art	on	, de	sea	28		i	6 years	
	v requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the buriat-transiteted by Physician/Medical Examir	Sequentially list confidence if any, leeding to impresse. Enter Under	nditions,	0.	Due to (o	r as a conse	quence of):					_			
760,	be ey	Cause (Disease or	Injury	C									<u> </u>		
687	death certificate e ettending phys ed for use as the	that initiated events resulting in death) l	Last		Due to (o	r as a conse	quence of):								
Box	nding use a			d											
	death e ette ed for	Part II. Other signif	icant conditions o	ontributing to death	n but not res	ulting in the	underlying ca	use gi	ven in Part I		23b. Did	tobacco use co	ntribute t	o the cause of death?	
P.0.	requires that the death certificat wen signed by the ettending phy hould be detached for use as the eted by Physician/Medi	His	seten	non							10	Yes 2 No	3 Pro	bably 4 Unknown	
	es this	-1111											T		
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io	Attanding For death. Sctor: After by the funer iffication:	2 ☐ Accident	5 Pending investigation	n	Doy 1 doi/	injury	М		Yes 2	No					
Division	tal or Attanding P is after death. In Director: After t led in by the funeration:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place of	Injury - At he		treet, factory,	office				(Street end Numi wn, Stata)	ber or Run	al Routa Number,	
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	Med	29b. Signeture and	of certifier	and manner	Juneu.		29c.	Licen	se number			29d. Date signe	ed (Month,	Dey, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #29c, 3/18/99 Certificate of Death Per Field Rep., Carroll County, wil 1. Decedent's Nema (First, Middla, Last) 2. Deta of Deeth 3. Time of Deeth March **Physician** 7:05 pm RUSSELL GEORGE STEVENS /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner UNION MEMORIAL HOSPITAL BALTIMORE CITY If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1♥M 2□F 212-28-3471 69 Director 10/6/1929 MARYLAND Usual Residence of Decedent the Manyland 10a Stete 10h County 10c. City, Town or Location ahow 10d. Insida City Limits r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified as MD. CARROLL FINKSBURG 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 SHETLAND 21048 RD. USA. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1951 If Yes, Give Year or Detes: 1952 14. Race - Amarican Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than ". College (1-4or 5+) Elementery/Secondary (0-12) MECHANICAL ENGINEER MANUFACTURING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GEORGE STEVENS MARGARET 2 KUES 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MADELINE F. STEVENS -WIFE 1900 SHETLAND RD., FINKSBURG, MD. 21048 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: If any Injury or METRO CREMATORY 3/16/99 BALTIMORE, MD. 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. m, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. 23a. Pert1. Enter the dished shock, or heart fulfille. Approximete Interval Between Onset end Death **Physician** Ischemic Cardiomyopathy /Medical Immedieta Cause (Finel disease or condition resulting in death) year Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of): physician a s the burial-Box 68760. Physician/Medical Due to (or es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Valvular Heart Disease 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to complation of cause of death? Congestive Heart Failure 24a. Was an eutopsy performed? Completed certificate 1 ☐ Yes 2 ☑ No Moepital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this carlificaleity lilled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1. Dinpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 DeNetural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Medical 1🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. To the Hosp within 24 ho To the Fune completely ii (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) end menner steted. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29ch ireg 37 ymber MO 389829 March 14, 1999 201 EUNIVERSITY FRWY. namnan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

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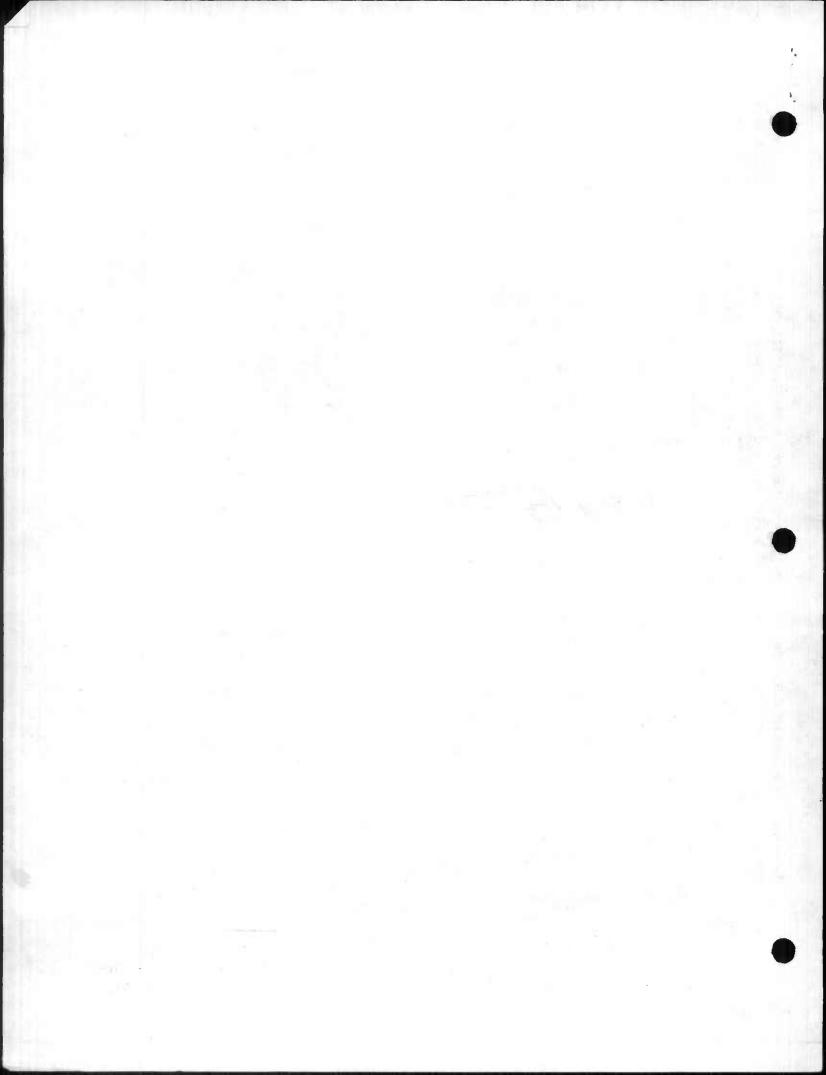
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31. Dete filed (Month, Day, Year)

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32. Registrar's Signature

BALTIMORE MD 2/2/8



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #29c, 3/18/99 State of Maryland / Department of Health and Mental Hygiene Per Field Rep., Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Kenneth MARCH :35 PM 16 1999 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Locetion of Deeth 4c. County of Deeth Examiner Carroll County General Hospital Westminster Carroll | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1Ū⁄M 2□ F 175-36-2599 Yrs. Director Aug 4,1944 Pennsylvania Usuel Residence of Decedent a or 28a-f show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Hampstead Director 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4811 Maple Grove Rd 21074 "natural", or Items 23a USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed The Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working iife. DO NOT use retired) 16b. Kind of Business/Industry ith end Mental Hygiene.
27 Is marked other than "r traumetic event, me Med Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Teacher Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Peges 1 end 2 should be nent of Health end Mental Charles Franklin Sholter Anna Mae Hollenbach 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e Patricia A. Sholter, wife 4811 Maple Grove Rd, Hampstead, MD 21074 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Department of Important: If any Injury or once. Carroll Cremations 3/21 Hampstead, MD 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Eline Funeral Home Teurs 934 South Main St, Hampstead, Md 21074 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediete Cause (Final ARYTHMIAS CARDIAC 1DAY disease or condition resulting in deeth) **Examiner** to (or es e consequence of) HRONIC RENAL FAILURE The lew requires that the death certificate be executed the buriel-tran Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Covonary Attery disease P.O. Box 68760, Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Meumonia of Vital Records, þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Be Completed 24e. Wes an eutopsy performed? After this certificate hes 1 Yes 2 No 1 Yes 2 Wo Attending Physician: 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No s efter deeth.
f Director: After this
od in by the funeral di Certification: 27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital o within 24 hours of To the Funeral Di completely filled in Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Yeer) P52035 29c. Ligg 52035 March INTERNIST 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Billingslea Building, Westmenista MD21157 295 Stoner Ave, CHACKO

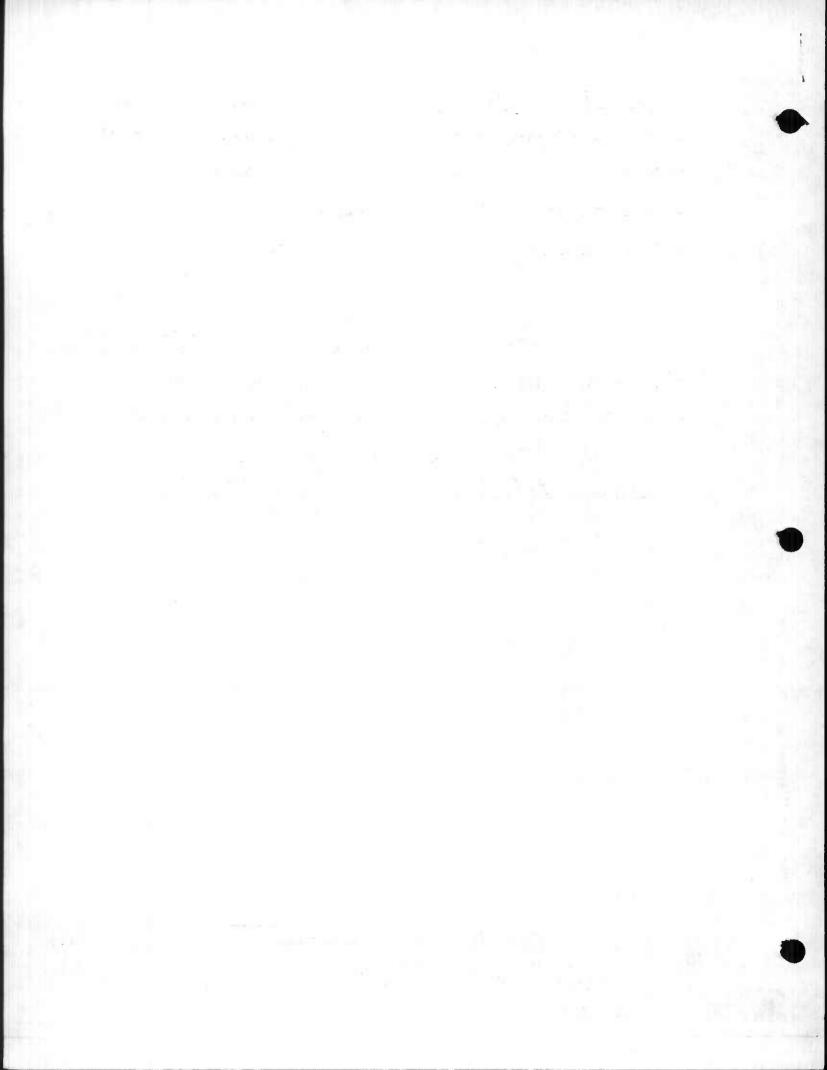
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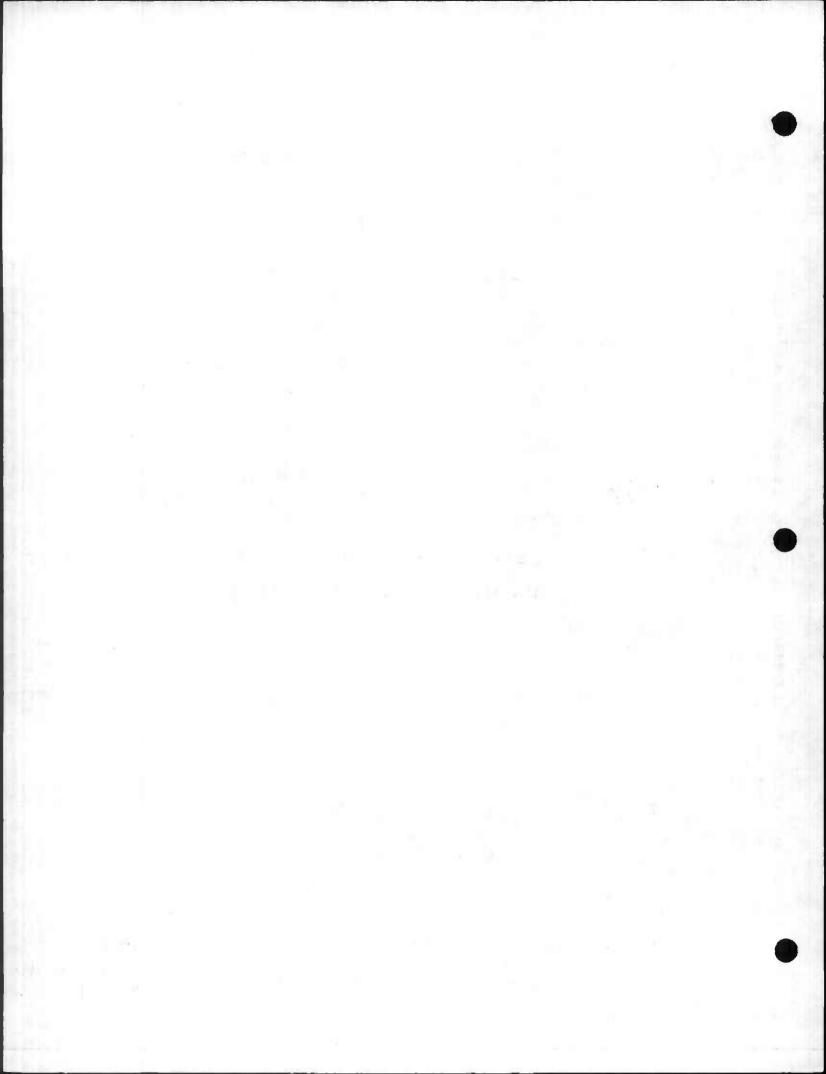
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32. Registrer's Signeture

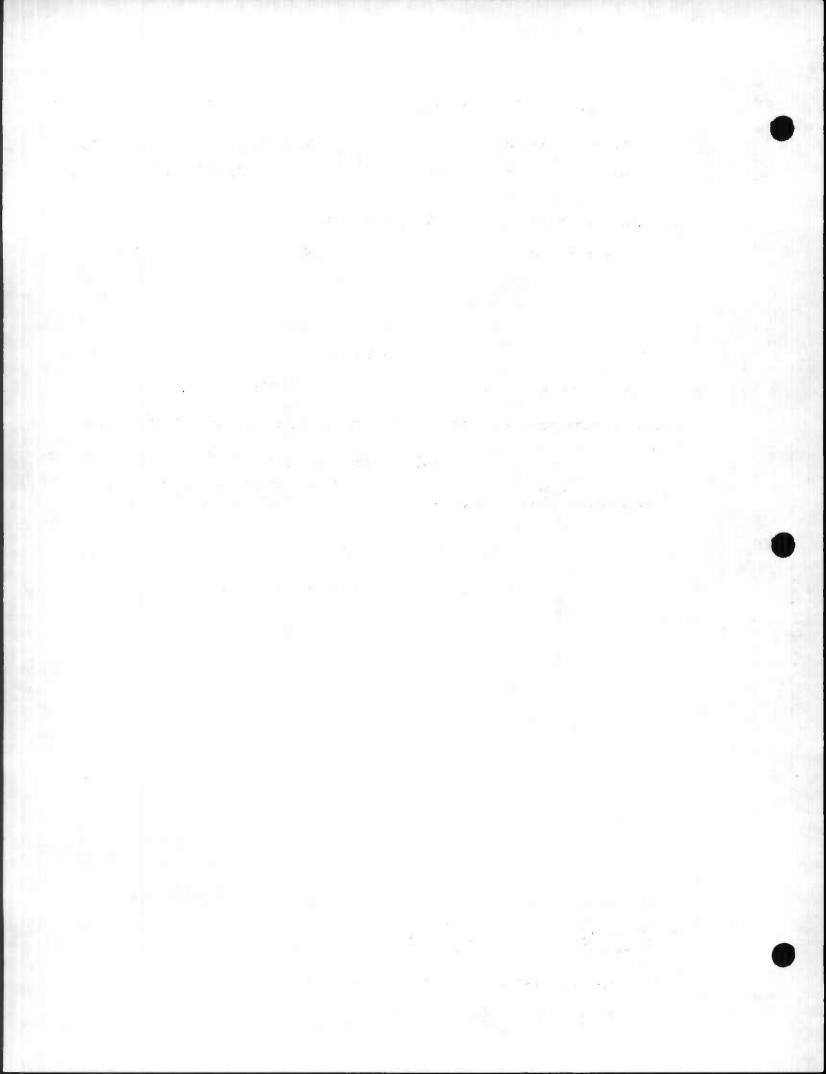


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Examiner Funeral Director	4a Facility Name (If not institution, give street end CARROLL COUNTY GENT 5. Social Security Number 6. Sex 220-18-1767	ERAL HOSPIT	AL WESTMII	or Location of Death	4c. County of Death CARROLL Year) 9. Birthp Coun	lace (Steta or Foreign try)			
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	Baltimore, Maryland	
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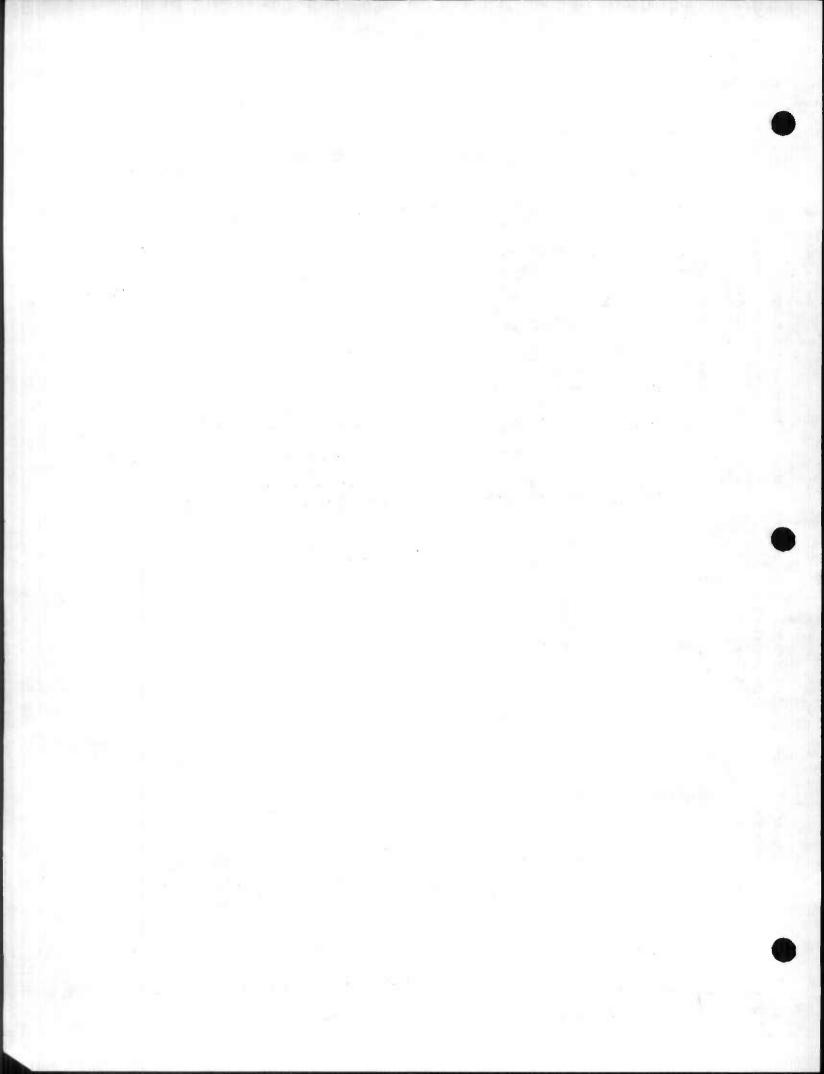
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	death with the Maryland	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Denament of Health and Maryla Librarians	

Division of Vital Records, P.O. Box 68760,

LAURA LEE SARTWELL	- 1 31	State of Mary		epartment of Certificate of		Mental Hy	giene Reg. No.	2	U954		
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puel se	Usuel Residence of Decedent 10a. Stete 10b. County	100	c. City, Town o					10	Od. Inside City Limits		
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ath with the Maryle 23e or 28e-f show ust be notified at rai Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?		
s 23a		Beach Road 12. Wes Decedent Ever	in II e II ni		619	(Specify Ves or No	U.S	.A.	an Indian		
hours after death with the Manyland ural", or fleme 23e or 28e-f ahow all Equalization profiled at 5d by Funeral Director		Amed Forces? 1 Yes 2 XNo If Yes, Give Yeer or Detes:	III U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No		erto Rican, etc.)		ck, White, o	etc.		
nad of	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) 12th 16a. Decedent's Usuel Occupation (Give kind of work done during most of work and of work done during most of work and of work done during most of work and of work done during most of work done dur						16b. Kind of B		lustry		
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c ever			Drury	110)							
permit. Peges 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the Mance. To Be Compl	19e. Informent's Neme/Reletionship (Gatton Type, Print)	19b. A	Mailing Address (Street	Shard of end Number or I			State, Zip	Code)		
and 2 selth e 27 ls	Sharon D. Owns/			853 Emera	ld Lane,	Californ					
F of He	20e. Method of Disposition 1 Durial 2 Cremetion 3 D		cemetery,	hisposition (Name of cremetory or other pa	-	Dete	20c. Location				
it. Per rtant: njury	4 □ Donetion 5 □ Other (Specific	y)	Metrop	olitan Cre		3/27/99	Alexan	dria,	VA		
Depa impo impo	22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 23a. Pert I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Intervel Between Intervel B										
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)			DNJ UN	43				Onset end Deeth		
ete be executed hysician and the bunal-transit dical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury										
phy stra	thet initieted events resulting in deeth) Last Due to (or es e consequence of): d.										
at the death certi by the ettending etached for use a	Part II. Other significant conditions o	ontributing to death but no	ot resulting in t	he underlying cause (given in Pert I.	23b. Did	tobacco use co	entribute to	the cause of death?		
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aw requir									ore autopsy findings pilable prior to impletion of cause death?		
The is						10	Yes 2□No	1	Yes 2□ No		
Physician: The this certificate ral director, pare ral Co.: To Be Co.:	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospitel:	0 F 10 - 40 -	otiona all post l	Mh. a.u.	eeth (Check only		(Cit	1 0000		
er this heral d	27. Menner of Death	28e. Dete of Injury (Month, Dey Yea	28b. Tin			Home 5 Res	how injury occur		" SCENE		
a fer death. I Director: After to in by the funers dertification:	1 Natural 5 Pending 2 Accident investigation	3 24 4	48	06M 11	Yes 2 No				munumon (
or Attended the design of the	3 Suicide 6 Could not be determined	building, etc. (S)	pecify)		9	City or To	(Street and Numi wn, State)		*4		
hours a meral Day filled by filled Ce	ROBOWRY RTZ3 FN. STMANY'S CO H										
To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.										
To the He within 24 To the Fu complete	29b. Signeture end title of certifier		29d. Date signe	ed (Month, i	Day, Year)						
	Mounte In	relfull		00	ME		MARCH 2	4, 19	99		
	30. Neme and eddress of person who	completed cause of deeth		(pe, Print) Penn Str	eet, Ball	timore. N	Maryland	2120	1		
State	31. Dete filed (Month, Day, Year)	32. Registrer's S		, ,		1					
Registrar	MAR 2.5.1	999 Depis	مهما	D. Ana	Mar						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death March 13 1999^{eer} **Physician** Day 2:05 am Vera Blondella Sherwood /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Garrett Co. Memorial Hospital Oakland Garrett 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Sept 7 Birthplace (State or Foreign Country)
 Md **Funeral** 220 16 7161 1 □ M 2 🖾 F Months Deys Hours Director 1927 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at Director 1⊠ Yes 2□No Garrett Shallmar 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ USA 21538 Shallmar Rd items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Manital Status Race - American indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married natural, or 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Be Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postoffice Postmaster 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Oscar Brady Alice Lechliter 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 67 permit. Pages 1 end 2:
Department of Health el
Important: If item 27 is
any injury or other trau Richard Sherwood Accident, Md 21520 PO Box 26 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Kalbaugh Cemetery Mar 16 99 Elk Garden W.Va 21. Signature of Funeral Service Licenson 22. Name end Address of Facility David A. Burdock FH arya 710 Church St. wdoci Kitzmiller, Md 21538 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Renal Failure year Examiner Due to (or es a consequence of): Examiner Arteriosclerotic Peripheral Vascular Disease years use es the buriel-tren Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): physician Physician/Medicai Due to (or as a consequence of): jo Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown high blood pressure þ , pege 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? high cholesterol peed certificate has 1 ☐ Yes 2 ☐ No tal or Attending Physician: The state death.

It after death.

In Director: After this certificate of in by the funeral director, pe Be 25. Wes case referred to medical 28. Piece of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in Medicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

DHMH 16 Bay 6/95

the Maryland

death

Pages 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiene.

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

altimore, Maryland 21215-0020

31. Dete filed (Month.

Thomas G. Johnson

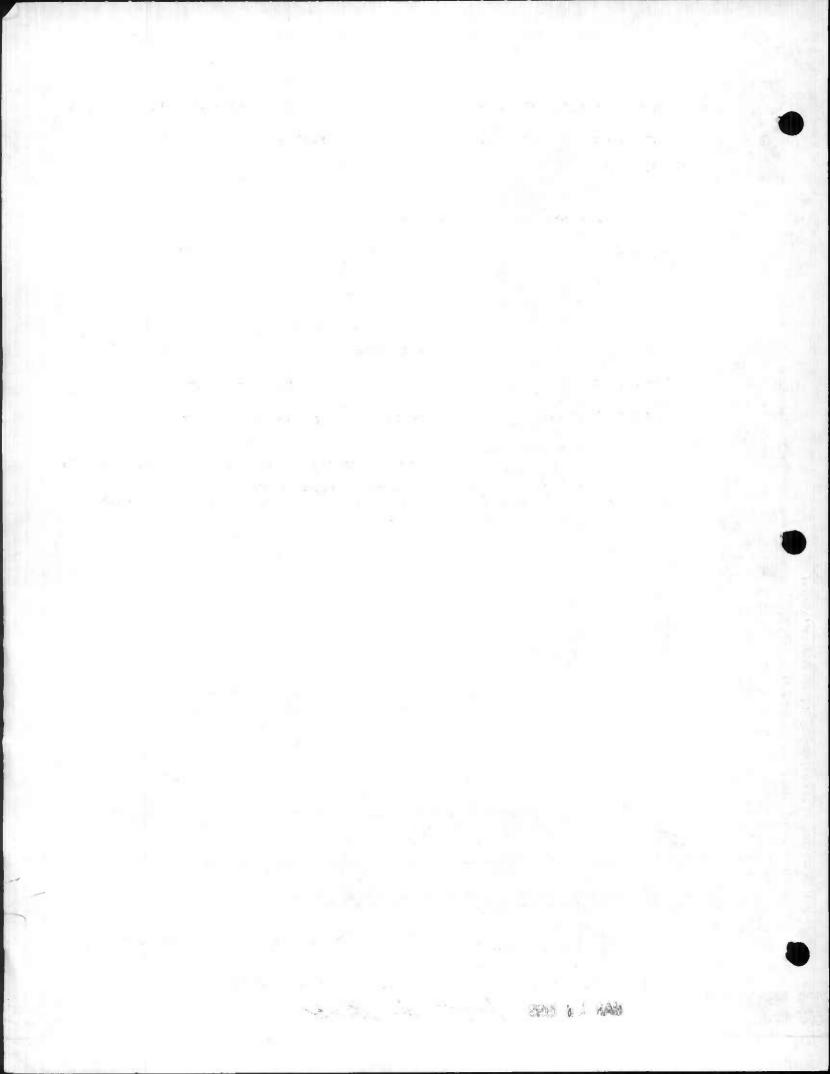
311 N.

32. Registrar's Signeture

4th St.

Oakland, Md

21550



سند و ا			Certificate	of Death		eg. No.	()				
sician	Decedent's Nama (First, Middle, Last				2. Dete of Dee	Day Yaar					
edical	MAUDE L. TAYL 4a Fecility Name (If not institution, giv.			4b. City, Town, or		13 1999 4c. County of Dec	5:15 PM				
miner	Fort Washington		or	Fort Washington Prince George's							
ral	5. Social Security Number 6. S		lest birthday) If Undar 1	Yaar If Under 24 Hrs. 8. Data of Birth 9. Birthplece (State or Fore							
tor	577-84-1783	□M 2⊠F 97	7 Yrs. Months I	Deys Hours Min.	July 1						
	Usuel Residence of Decedent 10e. State 10b. County	10c. C	ity, Town or Location								
to	Maryland Prince Go		ort Washingto	on			10d. Inside City Limits 1 ☑ Yas 2 ☐ No				
Director	10e. Street end Number	-	10f. Zip C		1	0g. Citizen of Whet C	ountry?				
ai	2904 Gosport Cou	ırt	20	744		U.S.A.					
Funeral	11. Marital Status	12. Was Dacedant Evar in U Armed Forces?	J.S. 13. Was Deceder If Yes, specify	nt of Hispanic Origin? (S Cuban, Maxicen, Puerl	14. Raca - Am Black, Wh						
by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes XIX No If Yas, Giva Yeer or Detes:	1 □ Yas 20	No Specify:		Specify:	Black				
	15. Decedent's Ed		Occupetion		16b. Kind of Busines						
pie	(Specify only highest gre Elementery/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind of work life. DO NOT use	done during most of war retired)							
Be Completed	None		Housewit			Private					
Be	17. Fether's Neme (First, Middle, Last)				me (First, Middle, i	Maiden Sumeme)					
2	Randy Colbert 19e. Informent's Name/Reletionship (Time Print)	10h Mailing Address (Mary H Street and Number or Re		r City or Town State	Zin Code)				
	Marion Viola Ta			Avenue, Oxo							
	20e. Method of Disposition	20b.	Plece of Disposition (Neme cametery, cremetory or other			20c. Location - City of					
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Remover from State	ryland Veter		1999	Cheltenha	m, Maryland				
	21. Signature of Funaral Sarvica Licensaa 22. Name end Address of Fecility 23. B. JENKINS FUNERAL HOME										
Important: I any injury o poce.	Behray	hopentin	- 7474 Lan	dover Road	, Landove	er, Maryla	nd 20785				
	23a. Part1. Enter the disease, or com shock, or heart failura. List only	plications that caused the dea one cause on eech line.	th. Do not entar tha mode	of dying, such es cardia	c or respiretory arr	rast,	Approximata Intervel Between Onset end Deeth				
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	diseese or condition resulting in death)	0.		COLU	10		2/18-				
ě		IM ET	or es e consequence of):	STO	1 IVE	2					
Examiner	Sequantially list conditions,	b. Due to (or es e consequence of):		^						
e E	Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	· CAT	D10 (PV)	LMONAR	y HA	GREST					
	thet initieted events resulting in deeth) Lest	Dua to (or as a consequance of):		,						
M/u		d									
Physician/Medic	Pert II. Other significant conditions of	ontributing to death but not re	sulting In the underlying cau	use given In Pert I.	23b. Did to	obacco use contribu	te to the cause of death				
Phy					1 🗆 Y	/es 2□ No 3□	Probably 4 Unknow				
by						244	Minn a day of the firm				
Completed					24a. Was a perfor		Were eutopsy findings available prior to completion of ceuse				
mpi							of deeth?				
0	25. Wes case referred to medical				1 D Y		1 Yes 2 No				
	examiner?	Hospitel: 1 Inpatient 2	☐ ER/Outpetient 3☐ DOA	Other:	eth <i>(Check only or</i> Home 5 ☐ Resid	enca 6 ⊡Other (S¢	pecify)				
o Be	1 Yes 2 No					ow injury occurred	,				
To Be	27. Menner of Deeth	(MODIN LIEV YEAR)	Ba. Date of Injury (Month, Dey Year) 28b. Time of Injury 28b. Time of Injury Work? M 28c. Injury at Work? 1 □ Yes 2								
To Be	27. Menner of Deeth 1 Matural 5 Pending 2 Accident investigation	n			28f. Location (Street end Number or Rural Route Number City or Town, Stete)						
To Be	27. Menner of Deeth 1 Natural 5 Pending	1	nome, farm, street, factory,	office			Hurar House rvumber,				
Certification: To Be	27. Menner of Deeth 1 Matural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Pending investigation of bedeemined	28e. Plece of Injury - At h building, etc. (Spec	nome, farm, street, factory, (City or Tow	n, Stete)					
Certification: To Be	27. Menner of Deeth 1 Matural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 27. Menner of Deeth 5 Pending investigation 6 Could not be determined	28e. Plece of Injury - At h	nome, farm, street, factory, (ify) owledge, deeth occurred et	the time, dete end plece	City or Tow	m, Stete) seuse(s) end manner	as stated.				
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edicai Certification: To Be	27. Menner of Deeth 1 Natural 2 Accident 3 Suicide 4 Homloide 29a. Certifier (Check only one) 27. Menner of Deeth 5 Pending investigation 6 Could not be determined	28e. Plece of Injury - At in building, etc. (Special Special S	owledge, deeth occurred et etion end/or investigation, in	the time, dete end plece n my opinion, deeth occu	e, end due to the curred et the time, c	euse(s) end manner date end placa, end d	as stated. ue to the ceuse(s)				

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Wilbur Terry March 14, 1999 1:13pm /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery County If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 579-42-0842 Yrs. 66 Director Jan. 17, 1933 Enfield, N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits abon. must be notified at Maryland Montgomery 1 Yes 2 No Director 289-1 Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or harms 23a or 13910 Castle Blvd. 20902 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 3/25/53 If Yes, Give Yeer or Detes: 3/16/55 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specity: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 8 Department of Health and Mental Important: If Ilem 27 is marked or any Injury or other traumatic eve Walter Terry Verdie Lowe Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Terry/ Wife 1107 Hill Rd. Hyattesville, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 3/22/99 Cheltenham, Md. 22. Name and Address of Facility Alexander s. Pope Funeral Homes 21. Signeture of Funeral Service License 5538 Marlboro Pike/Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tritervat Between Onset end Death **Physician** GASTROINTESTINAL BLEEDING /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner ARDIOMYOPATH physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760 ALCOHO Physician/Medical Due to (or es e consequence of) signed by the a P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: after death. 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28b. Tima of 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 Natural
2 Accident 1 □ Yes 2 □ No Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. Medical (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) D40804 Eliamekhin MD 03/14/1999 KEWAL K. SHARMA 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 6 1999

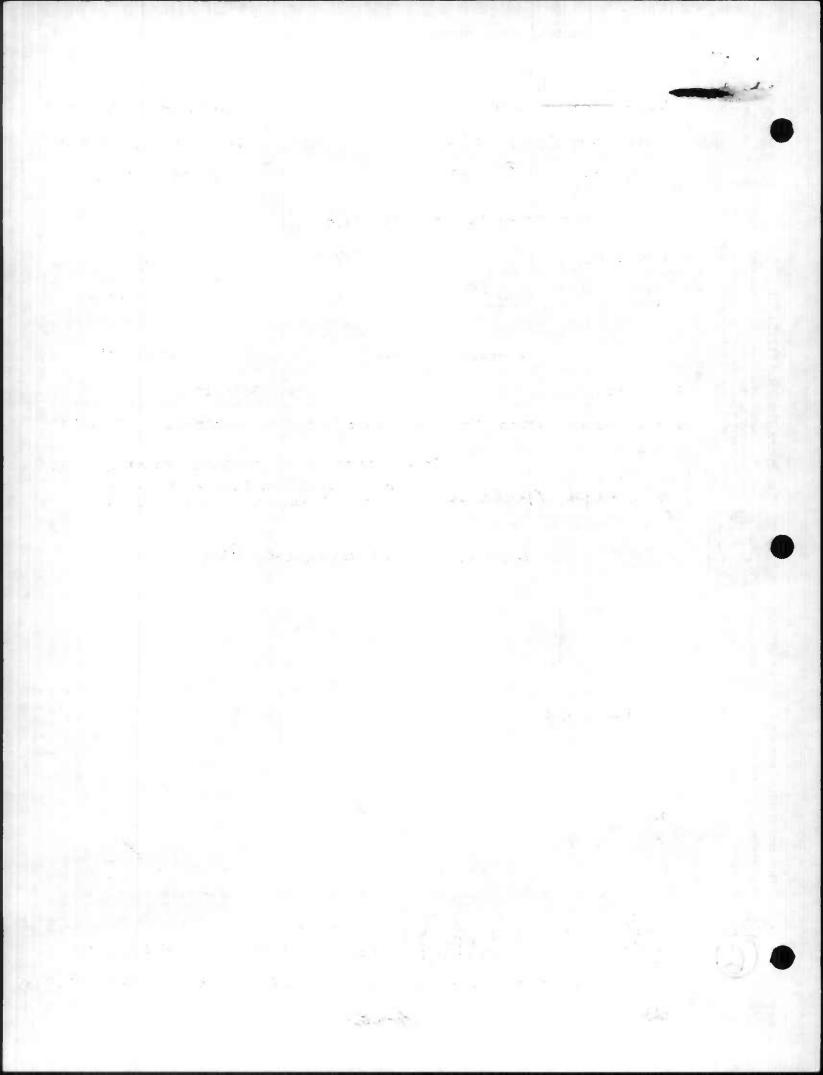
10620 GEORGIA

AVE # 114 SILVER SPRING MD-20902
82. Registrer's Signeture
6. Localis

DHMH 16 Rev 6/95

48.

item	#1.Per M.E.PGC 3-19-99 cr Certificate of Death	2. Data of D			Time of Deeth
icián dical	Selma Dorothy Thomas	MARC	1	Yeer 199	1025
niner		or Location of Das		1. 1.4	, ,
		3PHNGS	PRINCE		
al or	5. Social Security Number 6. Sax 1 M 2 N F 7. Age (In yrs. last birthday) If Undar 1 Yaer If Under 24 Months Deys Hours N 92 Yrs.	Hrs. 8. Date of B (Month, L		9. Birthpieca Country) Georg	(State or Foreign
-17	Usuel Residence of Decedent	3-20	-00		
	10a. Stete 10b. County 10c. City, Town or Location				nside City Limits ☐ Yes 2☐ No
Director	Md. Prince George's Ft. Washington				T 162 5 110
	10e. Street end Number 10f. Zip Code		10g. Citizen of W	/het Country?	
Funeral	511 Moat Way 20744 11. Marital Stetus 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin'	2 (Cassile Van er b	USA	- American Ir	dian
by Fun	11. Marital Stetus 1 □ Nevar Married 2 □ Married 1 □ Nevar Married 2 □ Married 1 □ Yes 2 □ No if Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin' if Yes, specify Cuben, Mexican, Pi 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	uerto Rican, atc.)	Blec	k, White, etc. Black	
Pe	15. Decedent's Education 16e. Decedent's Usual Occupation	4.1	16b. Kind of Bu	siness/Industr	у
Completed	(Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	working			
0	4 yrs. Nurse		Hosp:		
Be (17. Father's Neme (First, Middle, Last)	Name (First, Midd	lle, Maiden Surnem	e)	
2		Griffi			
11	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of Street and Number of				
	Maxzeller L. Thomas, Son 511 Moat Way, Ft 20b. Method of Disposition 20b. Place of Disposition (Name of	. Washi:	ngton, N		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramovel from State	Dete	200. Location	City of Town,	31010
	4 Donetion 5 Other (Specify) Lincoln Memorial 21 Signature of Juneral Service Licenses 22. Name and Address of Facility	3-22-9	9 Suit	land,	Md.
	Ralph Williams 517 11th St.,	SE, Was	sh., DC		3
	23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart teilure. List only one cause on each line.	diac or raspiratory	errest,	Inte	proximete prvel Betwaen set and Deeth
n/Medical Examiner	Due to (or as e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of):				
icla	Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert i.	23b. Di	id tobacco usa cor	tribute to the	cause of death'
by Physiclan/M	DEMENTA		Yes 2 No	3 Probabl	
Completed b		24e. We pe	es en eutopsy normed?	availab	outopsy findings la prior to stion of cause h?
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ate	30. Name end eddress of person who completed fause of deeth (Item 28a) (Type, Print) MARID F. GOLUG JR MD 3601 HOSPITAL DRIVE 31. Date filled (Month, Day, Year) MAR 1 9 1945 32. Registrer's Signature	E CHEV	erly m	ARYLAN	IP 2078

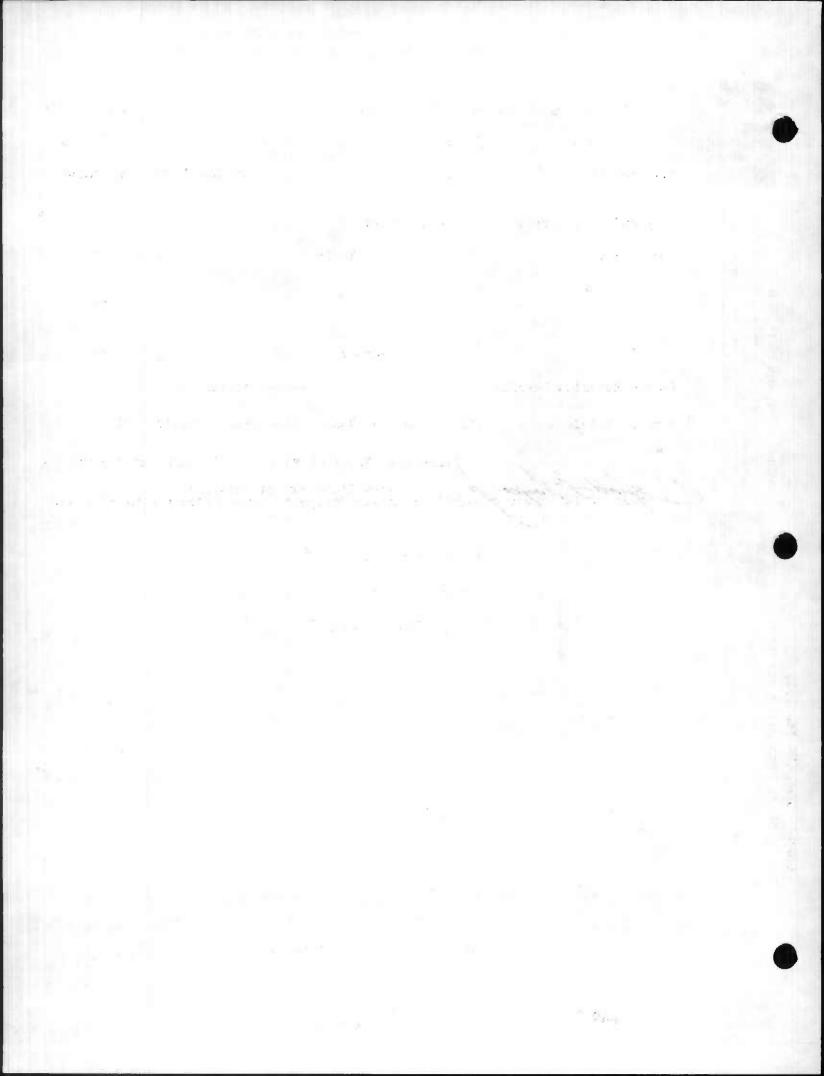


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death JOSEPH O. UDOIDEM 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Day 1999 **Physician** JOSEPH O. UDOIDEN FEB. 28, 9:53 AM. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10110 AEROSPACE DR. GREENBELT P.G. 5. Social Security Number 7. Aga (In yrs. last birthday) 24 Yrs. 8. Data of Birth (Month, Day, Year) 12-16-74 9. Birtholace (State or Foraion **Funeral** 1**X**) M 2□ F Months Davs Hours 237-87-5331 Nigeria, W. Afr Director Usual Rasidance of Dacedant the Merylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at 1□ Yas 2□ No Director Md. P.G. Lanham, 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9977 Goodluck Rd. #104 20706 Nigeria, W. Africa Funerai death 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Year or Datas: **Reme** Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, traumatic event, the Madical Examiner Bleck, Whita, atc. filed within 72 hours after XXNaver Married 2 Married ŏ Maryland 21215-0020 1 ☐ Yas 25th No Specify: Black Specify: PY 3 ☐ Widowed 4 ☐ Divorced natural', 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) el Hygiene. College (1-4or 5+) Etementery/Secondary (0-12) Student College permit. Peges 1 end 2 should be file Department of Heelth and Mentel Hyr Important: If item 27 is marked othe enry injury or other traumatic event, pages. 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fether's Neme (First, Middle, Last) Alexes Udoiden Sussana Akpan 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 915 N. 52St. #2041 Phoenix, Az.85008 Joseph Akpanikat cousin Baltimore. 20b. Plece of Disposition (Name of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 M Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 3-16-99 Washington, D.C. 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Olivet 22. Nama and Addrass of Facility 21. Sign June of Funaral Service Licensae Universal Mortuary 411 Kennedy St. N.W. 1. Enter the disease, or complications that caused in the lath. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Gunskot Wounds /Medical immediata Causa (Final diseesa or condition rasulting in death) Examiner Examiner physician end the burial-tran Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last Due to (or es a consequence of): Physician/Medicai Dua to (or as a consequance of): 98 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to complation of causa of deeth? 24a. Was an autopsy performad? Completed peed Ha Yas 2□No 1 Tyas 2 No certificate Division of Vital 25. Was cesa referred to medicel Be 26. Placa of Deeth (Check only ona) aminar? AT Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 Rasidence 6XX thar (Specify) 1 X Yas 2 No 0 this SCENE 27. Mennar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28a. Deta of injury (Month, Day Year) After 1 Natural 5 Panding 1 ☐ Yes 202 No subject shot Investigation 2128/99 2 Accidant 940 efter death Director: 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 10110 Aero Space: Ref 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred of the time, date and place, and dua to the cause(s) and menner es stated.

2X Miedical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred of the time, data and place, and dua to the ceuse(s) 6 Mospital of 24 hours e edicai 29a. Certifier (Check only one) completely To the I within 2 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licansa number O.C.M.E. MARCH 01, 1999 30 Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) R 111 Penn Street, Baltimore, Maryland 21201 32. Ragistrer's Signatura 31. Data filad (Month, Day, Yaar) State MAR 1 7 1999

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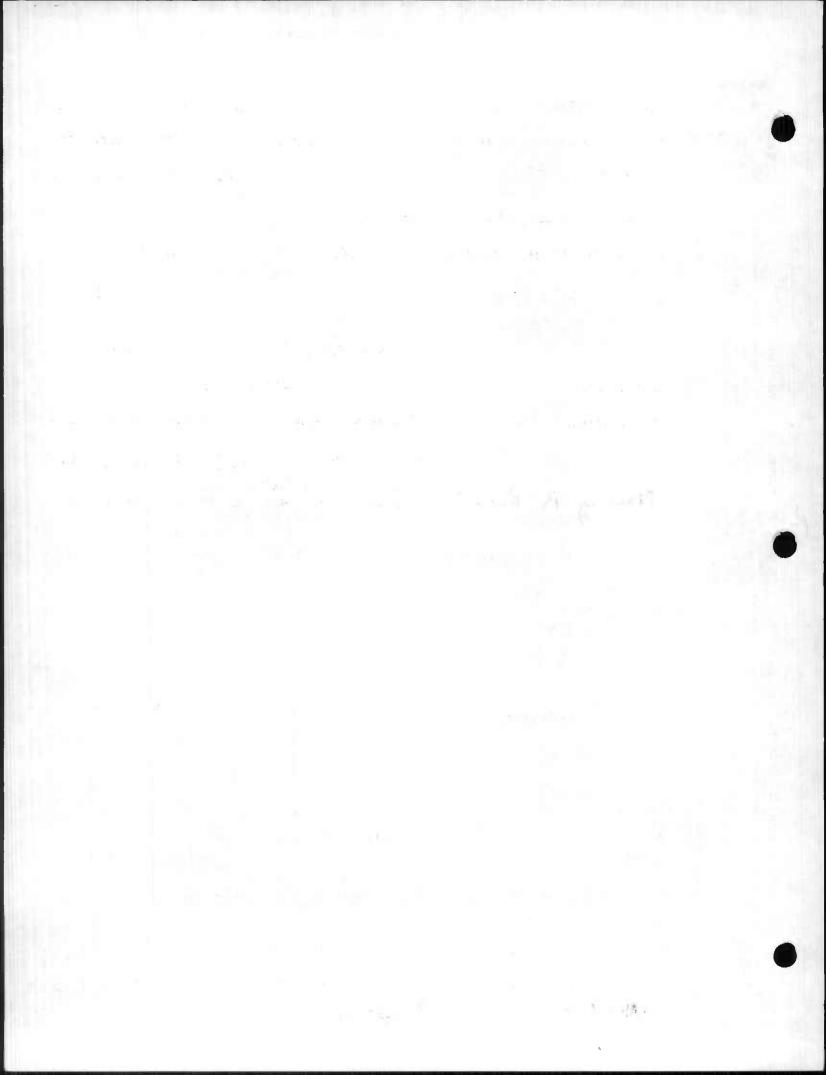
DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Decedent's Name (First Assista, Last) Dece				C	ertifica	te of	Death		R	eg. No.			
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Manor Care Health Services Prince George		4a Facility Nama (If not Institution, git	va street and number)				4b. City, Tov	wn, or Locat	ion of Death	4c. County	of Deeth		
So Souls Security Number 6. See 292-94-984 100 w 20F 84 vr. 84 vr. 86 vr. 100 w 20F 84 vr. 84 vr. 86 vr. 100 w 20F 84 vr. 86 vr. 100 w 20F 100 w		Manor Care Hea	1th Service	S			Largo			Princ	e Geo	rge's	
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21. Signature of Funeral Service Licenses Name		1 Burial 2 Cramation 3 D	•	cemetary,	cramatory or	othar pla	ica)	03,	/19				
29a. Part I. Enter the disease) or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, interval Batter of the death of the cause of		21. Signatura of Funaral Sarvica Lica	nsaa P -	+'	J. B.	ENK	INS FU	NERAL	HOME				05
Immediate Causa (Final disease or condition rasiling in death) Due to (or as a consequence of): Application		23a, Pert1, Entar tha disaese, or con	polications that caused to	ha daeth. Do not	antar tha mo	da of dv	ng, such as	cardiac or re	Landov espiratory arr	er, mai	yranı	Approxim	ate
Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Part It. Other significant conditions contribution to the cause of lives 2 No 3 Probably 4 Law and autopsy fire available prior to completion of conditions of	ical iner	diseasa or condition	a. Gast	Due to (or as a con	8h no	4	Blee	edir	9 col	fration)	Ide	ay
Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 U	cal Exam	Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or Injury that initieted events	с.										
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29a. Certifiar (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)	cation	1 ØNatural 5 ☐ Panding 2 ☐ Accident investigation	(Month, Day		ry			No					
29a. Certifiar (Check only one) 1 Cartifying Physician: To the best of my knowtedge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and dua to the cause(s) and mannar as stated. 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)	Certifi		datarmined 20a. Placa of Injury - Actionia, fallin, Straat, factory, office							areet and Nurr n, State)	iper or Rur	ar Houta Nu	imber,
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30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Suresha. Patelmid. 750/Surratts Rd # 367. Chinton. MD20735	/			ath (Item 23a) (Ty	rpe, Print)	-0	142	,2 1	0		200	2	

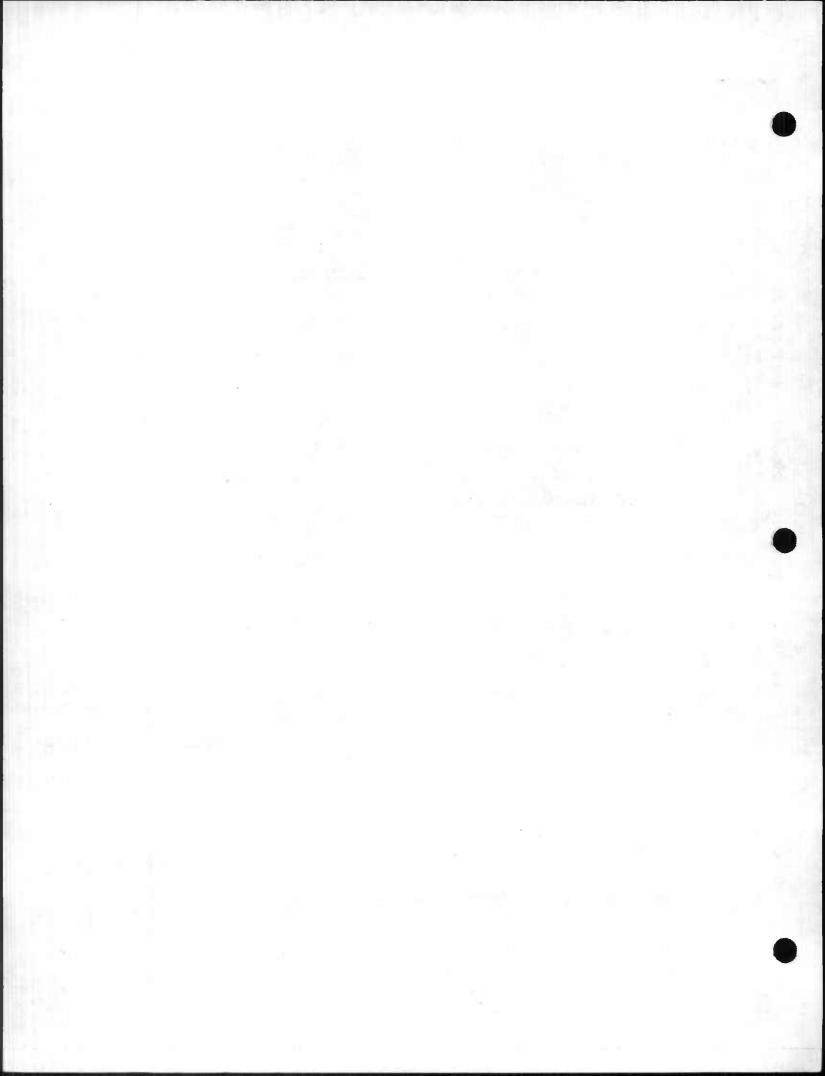


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima ol Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month 1 Day **Physician** 1999 Ervin Valenta March Harvey /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll County General Hospital If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) June 23, 1932 9. Birthplace (Stata or Foraign **Funeral** Days Hours Wisconsin 12 M 20 F Months 388-28-1029 66 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Nerna 23a or 28a-f ehow Westminster 1 ☐ Yas 2 No Director Carroll Maryland å, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21157 1644 Exeter Rd. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c. Department of Health and Mental hygiene. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Examinations. Black, Whita, atc. 1 XYas 2 No If Yes, Giva Year or Datas 1952-54 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) radar 12 electrical engineer Baitimore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) 8 Ella Dahl Anton Valenta 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Westminster, MD 21157 Catherine I. Valenta/ wife 1644 Exeter Rd. 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod ol Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 3/20/99 Westminster, MD Meadow Branch Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensi Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each seed to be death. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final epsis with vancomytin disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Oneum onea physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): chronic obstructive pulm ona Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 45 Nown Division of VItal Records. δ 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificete has birector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: '24 hours after death.'
Funeral Director: After this certifice 25. Was casa referred to medical axaminar? 8 26. Place of Death (Check only one) Hospital: 1 Hapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To funeral 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directorn pletely filled in by Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and manner as stated.

| Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) march, D0052479 30. Name and address of person who completed cause of death (Herm 23e) (Type, Print) LISH Kim, M.D. at carroll Ho Sputul at 200 memorial thenne, westminster MD 21151 county Ger 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAR 2 2 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Daath Month Day March 6, 1999 **Physician** Charles Samuel Wendel 5:50pm. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's Co. | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 9. Birthplaca (State or Foralgon Country) | Sept. 24, 1922 | Washington, D.C 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 187 M 2□ F 76 Yrs. 579-05-8315 Director Usual Rasidance of Decedant 10a Stata 10c. City, Town or Location 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Prince George's Lanham 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? items 23e 6401 Brightlea Dr. 20706 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 A Yas 2 □ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married ò 1 ☐ Yas 2 2 No Specify: Specify: White by 3 ₩ Widowed 4 Divorced *naturef Completed 15. Dacadent's Education 16a. Decadant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) (Specify only highast grada complated) nd Mental Hygiena. marked other than Elementary/Secondary (0-12) Callege (1-4or 5+) Editor Magazine permit. Peges 1 and 2 should be flie Department of Health and Mantal Hy Important; if Item 27 is marked othi any Julyy or other traumatic event, potes. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be John Herman Wendel II Frances Blanche Brown-Price 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Jay Steven Wendel/Son 6401 Brightlea Dr. Lanham, MD 20706 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 3/10/99 Falls Church, VA 4 ☐ Donation 5 ☐ Othar (Specify) National Memorial Park 22. Nama and Addrass of Facility a of Funeral Sarvice-Licenspa National Funeral Home 7482 Lee Highway Falls Church, VA 23a. Part 1. Entar the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in lure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in death) Examiner The law requires that the death certificete be executed Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated avants rasulting in daath) Last pue the burial-tren Dua to (or as a consequence of): attending physician for use as the buria Physician/Medical Dua to (or as a consequence of): signed by the at d be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peeu complation of cause of death? this certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: Be 25. Was casa referred to medical 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 2 1 ☐ Yas 2 ☑ No 11 Inpatiant 2 ER/Outpatiant 3 DOA 27. Mannar of Death Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred After 5 Panding invastigation ours after dean 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 ☐ Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Numbar or Rural Routa Number, City or Town, Stata) 4 Homleida To the Hospital on within 24 hours af 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar 29b. Signature and title of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) ROAD LAUREL, MD 20707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Data filad (Month, Day, Year) MAR 1 5 1999 32 Registrar's Signatura

Baltimore, Maryland

P.O. Box 68760,

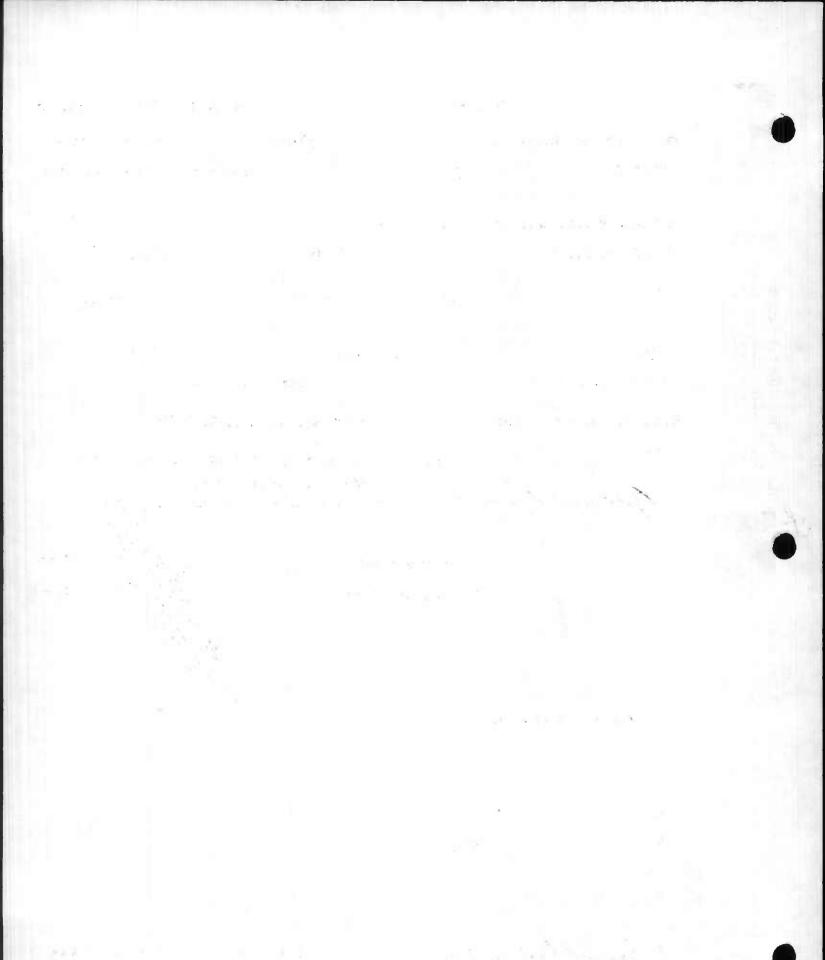
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Division

NBI: - H

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	KIN	and ?	Kend		-					m, MD_2	2000	/	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certific	ate of Death		Reg. No.	
Phys	lcian dical	1. Decedent's Neme (First, Middle, La	est)	IRZ.		2. Date of Dea Month	-	3. Time of Death
	niner	4a Facility Name (If not institution, give NEW N		OME	4b. City, Town, o	Location of Death		of Death PROLL
Funer Direct	_	213-74-1867	Sex 7. Age (In yr	Yrs. Isst birthday) If Un Monti	der 1 Year If Under 24 Hr hs Days Hours Mi			9. Birthplace (State or Foreign Country)
faryland show	20	Usual Residence of Decedent 10a. State 10b. County CARRO		City, Town or Location	THA			10d. fnside City Limits 1 ☑ Yes 2 ☐ No
ith with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 3332 MAIN 5			Zip Code 21102	17	10g. Citizen of V	
5-0020 72 hours efter death with the Maryland natural, or flems 23a or 28a-f show pleat Examinen must be notified at	by Funera		12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (specify Cuben, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Raci Blac Specify	e - American Indien, ok, White, etc.
T C 1 4	Completed		ducation	16a. Decedent's U (Give kind of life. DO NO HOME!	work done during most of w Tuse retired)	orking	16b. Kind of Bu	HOME
Maryland 212: d 2 should be filed within h and Mental Hygiena. 7 is merked other than traumatic event, Its M.	To Be Co	FRIEDRICK V	N. SchRAG	3E	18. Mother's No	ame (First, Middle, E Sct		ne)
e, Mary 1 and 2 shou Health and IN em 27 is main ther traumain		19a. Informant's Name/Relationship (ROSEMARIE HEM	Type, Printy DAUGHTE,	BALTIMO	ess (Street end Number or LENT DAK R DEL, MARY LA	Rurel Route Numbe	er, City or Town,	
Baltimore, bemit. Pages 1 a Department of Hea important: if item:		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Themoval from State	Place of Disposition (Incometory)	Veme of prother place) EM ETERV	3/22/99		City or Town, State
Baltimo pemit. Pages Department of important: if it any Injury or	9000	21. Signature of Puneral Service Licer	nage .	22. Name 412 V	and Address of Fecility PE	itts Fun	ERALHO	OME & Chapel
Physicia	_	23a. Parti. Enterpre diseese, or com abook, or dean failure. List only	one ceuse on each line.	eth. Do not enter the m	node of dying, such as cardi	AEV CHN ac or respiratory an	rest,	Approximate intervel Between Onset and Death
/Medica Examine	r	Immediete Cause (Finel disease or condition resulting in deeth)	a. Old Due to	(or as a consequence	of):			101 yr
and and al-fransit	Examiner	Sequentially list conditions, if any, leading to immediate	b. Sepsi	or as e consequenca	of):			Zenh
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O. Box he daeth cer the attendin ched for usa	Physician/	Part ii. Other significant conditions of	dontributing to death but not re	esulting In the underlyIn	g cause given In Pert i.	23b. Did to	obacco use cor	itributa to the cause of death?
as thet the da igned by the detached	by Phy					101	'ee 2 No	3 Probably 4 Unknown
Of VITAL RECORDS, Physician: The law requires the certificate hes been signe rail director, page 2 should be or	Completed					24a. Was a perfor	in eutopsy med?	24b. Were autopsy findings available prior to completion of cause of deeth?
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Of VITA Physician: rthis certific rral director,	-	1 163 2E 140		□ ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Resid	ence 6 DOthe	
nding ath. r: After	Certification:	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be 4 Homloide determined		28b. Time of finjury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	Treet end Numbe	ed er or Rural Route Number,
DIVIS To the Hospital or Atte within 24 hours aftar de To the Funeral Directo completaly filled in by th	edical Cer	Medical Exam	ysicfan: To the best of my kn niner: On the basis of examin	nowledge death occurre	ed at the time, date and nice	e and due to the o	auco(c) and ma	nner es stated.
To the Vithin 2 To the Comple	Med	29b. Signature end title of certifier	end manner steted.		29c. License number	2	29d. Date signed	(Month, Dey, Year)
}		Jahm Ind	ldum		D 2 2 4 4	3	3 '	1299
		30. Name and eddress of person who o	Poole (ite	em 23a) (Type, Print)	John W. Midd	leton, M.	.D.	2299 nd 21157
S	tate	31. Date filed (Month, Dey, Yeer)	32. Registrar's Sign	nature		- VIII		

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	rroll County, wjl Certificate of Death						Reg. No.				
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ctor	MD Carrol	L S	ykesvill				Yes 2□ No				
al Director	10e. Street end Number 7200 Third Av	venue	1	10g. Citizen of Whet Cour USA			y?				
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yas, Giva Year or Detes:		pecify Yes or No- to Rican, etc.) 14. Race - American In Black, White, etc. Specify: White			c.				
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Be	17. Fether's Neme (First, Middle, Last)	m			18. Mother's Name (First, Middle, Meiden Sumeme)						
To	Warren B. Dunhar 19e. Informent's Neme/Reletionship (T)		19b. Meiling A	ddress (Stree	Margene Brown (Street end Number or Rurel Routa Numbar, City or Town, Stete, Zip Code)						
	Frederick William	1	7200 Thi	rd Ave.	C-138 Sykes	Sylesyi ville MD	21784	21784			
	20e. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ f 4 □ Donetion 5 □ Other (Specify,	20b. Piece of Disposition 20b. Piece of Disposition 20c. Location - City or Town, Stete 20c. Location									
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville MD 21784										
	23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Betwean Onset and Deeth										
	Immediate Cause (Finel disease or condition resulting in death) a. Cerebrova scular accident										
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af Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.										
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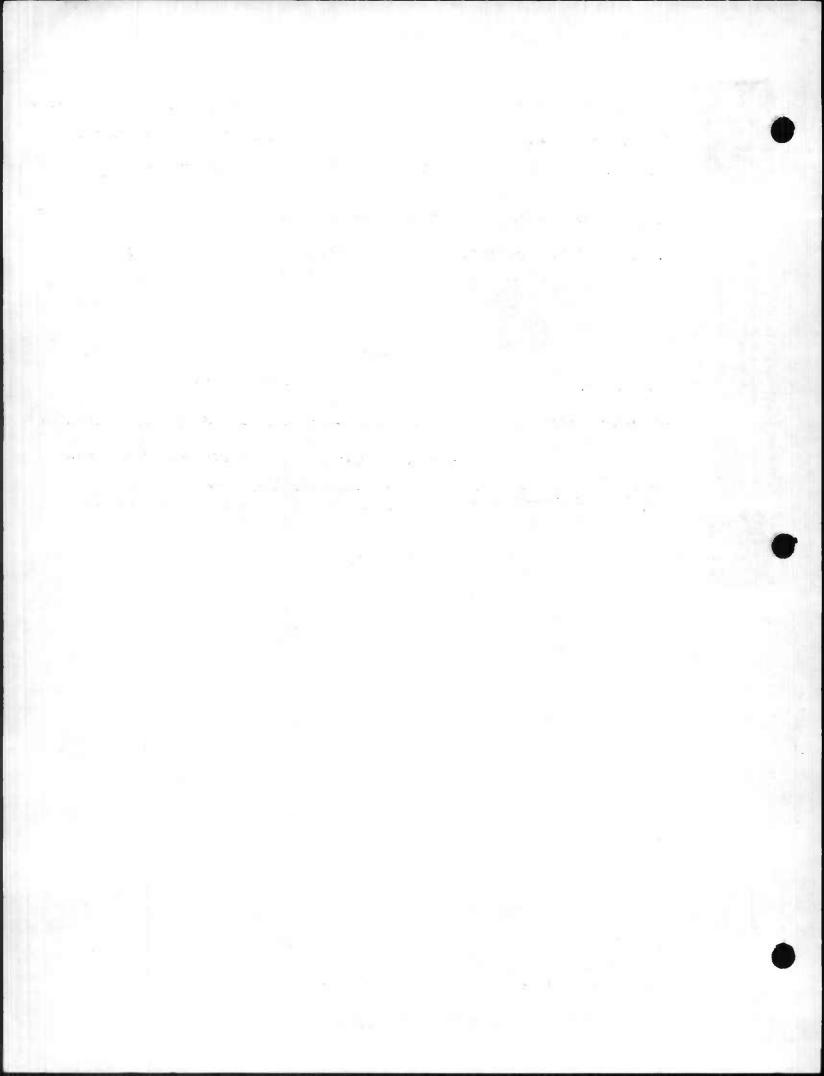
COFFMAN WARE

Certificate of Death 2. Date of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month March 20, 1999 **Physician** 2:20a.m. Carl Coffman Ware /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner St. Mary's Lexington Park Bayside Care Center 8. Date of Birth Months Day Year 1905 6. Sex 12 M 2 F If Under 1 Yeer If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 94 Yrs. 407-10-9016 Kentucky Director Usuel Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Leonardtown Director Maryland St. Mary's 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number r than "natural", or items 23s or the Medical Examiner must be 20650 Newtowne Village Apartments U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiene. important: If item 27 is merked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status 1 Never Marriad 2 Married 1 Yas 2 No Specify: altimore, Maryland 21215-0020 by White 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Specialties Salesman 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Candice Given Robin C. Ware 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 40907 Cooper Drive, Leonardtown, Maryland 20650 Paul Stotler/Step-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia 3/22/99 Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, PA schael Sardiner P.O. Box 270, Leonardtown, Maryland 20650 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** about Immediate Cause (Final disease or condition resulting in death) /Medical Acute Cardio-respiratory one day **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Doeummia that the deeth certificate be executed ettending physician end for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) Records, P.O. Box 68760, Gastroin testinal bleeding thet initiated events resulting in deeth) Last Due to (or es a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 ☐ Yas 2 No brain Syndrome Organic þ 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? Completed completion of cause of death? s certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Attending 1 b Naturel 5 Pending 1 Tes 2 No death. investigation Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide in 24 hour. the Funeral Directory filled in by 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide 0 Hospital 1 Certifying Physictan: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier completely (Check only one) within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50044 March 22, 1999 D.m. A. Rahmau, MD) DIV 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Hollywood, Md. 20636 Dr. Mohammad A. Rahman 31. Data filed (Month, Day, Year) 32. Registrar's Signature Sparks MAR 23 1999

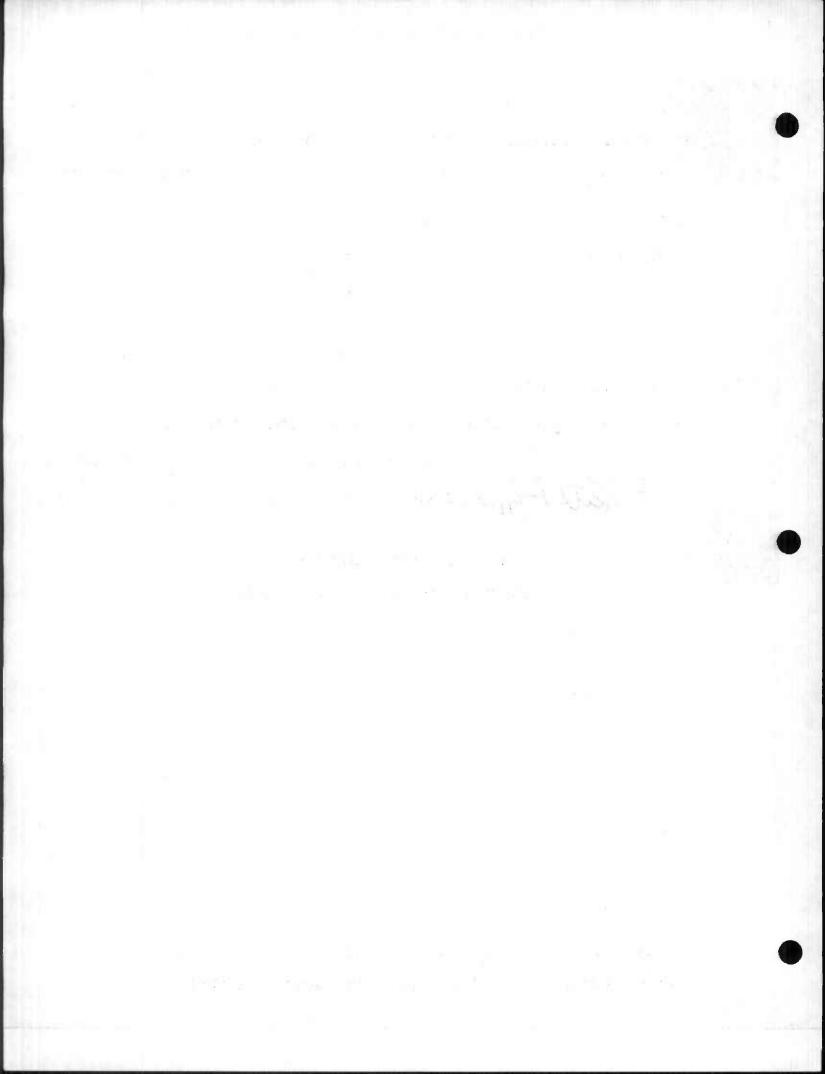
DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_				State of	Maryiai		tificate of	Death	vientai my	Reg. No.	9	10968	
	Physici /Medi		Decedant's Name (First, Middle, Last) BARBARA LEE WALTERS						2. Dete of De Month 03	Day 22	Yeer 99	3. Time of Feeth	
Exami			4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth										
			PENINSULA REGION					SALISBURY WICOMICO					
aryland 21215-0020 should be filed within 72 hours efter death with the Marylend	Funeral Director	tor	218-24-7317	Age (In yrs. last birthday) 68 Yrs. If Under 1 Year Months Deys			Hours Min.	(Month, Dey, Year) Co			elaca (Steta or Foraign etry) CYLAND		
	/lend		Usuel Rasidence of Decedent 10a. Stata 10b. County	<u> </u>	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits	
	Man		MARYLAND BALTIMORE								1 Yes 2 □ No		
	or 284	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Coun	itry?	
	th wil	To Be Completed by Funeral D						2		U.S.A.			
	urs efter daa II', or items kandoor m		11. Maritel Status 1 ☑ Nevar Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Forced 1 Tas 2 If Yes, Give Year or Deta	es? ∭No	If	Ves Decedent of I i Yas, specify Cub ☐ Yas 2X No	dispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ca - Amaric ck, White, V: WH		
	within ane. then "		15. Decedant's (Specify only highest Elementery/Secondery (0-12) 1.2	lor 5+)	16e. Decedent's Usuel Occupetion (Give kind of work done during most of wo life. DO NOT use retired) LINE WORKER			king	16b. Kind of Business/Industry LUGGAGE COMPANY				
	al Hygi other		17. Fether's Neme (First, Middle, La	ast)		LINE	WORKER	18. Mother's Nen	ne (First, Middle			ANI	
	s 1 and 2 should be filed f Health and Mantal Hyg tam 27 is marked other other traumatic event,		THOMAS H.	WALTERS				ELVA		PRICE			
	2 shot and N is mai		19a. Informant's Name/Reletionshi	p (Type, Print)		19b. Meilin	g Address (Street	end Number or Ru	ral Route Numb		Stete, Zip	Code)	
	end 2 paith n 27 i		RICHARD LEE WALT	ERS - BRO			BOX 5862	COLORAD	O SPRIN	GS,CO.	8091	1	
	T of H		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	B □Removel from Sta		Plece of Dispos cemetery, crem	sition (Neme of netory or other ple	се)	Dete	20c. Location	City or To	wn, Stete	
	tman tant:		4 Donetion 5 Other (Spe	ecify)		MBRIDGE	CREMATO)RY	3-25-99	CAMBRI	DGE,	MARYLAND	
	Departimon Importanting		21. Signature of Funeral Survion Li	oensee	10-	22.	. Name end Addre	ess of Fecility		705 E.	MAIN	ST.	
	402.00		23a. Pert1. Enter the diseese, or c shock, or haart failure. List or	1 typo	J UF			NERAL HO			BURY,	MD 21804	
58760, icete be executed III	Medicale be executed attending physician and attending physician and attending physician sit at the burief-transit	/Medical Examiner	Immediate Ceusa (Finel disease or condition resulting In death) e. CHRONIC RESPIRATORY INSUFFICIENCY Due to (or es e consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or es e consequence of): c. Due to (or es e consequence of): Due to (or es e consequence of): c. Due to (or es e consequence of):										
Box	death certif e attending id for use a	clar	Det II Other also Meant and Mark and Ma						anh Did	23b. Did tobacco use contribute to the cause of death?			
Records, P.O. e law requires that the chas been signed by the	the che	ation: To Be Completed by Physician/M	Pert II. Other significent conditions contributing to death but not resulting in the undarlying cause givan in Part I.							1 No 2 No 3 Probably 4 Unknown			
	requiras been sign should be				-				24e. Wes	s en eutopsy ormed?	24b. Wa	are autopsy findings ellable prior to mpletion of causa death?	
	0 - 0								10	Yes 2 No		Yas 2□ No	
ā	Iclan: The		25. Wes casa refarred to medical					26. Pleca of Dea				3143 20110	
Ing After	ysician: is certific director,		axeminar? 1. ☑ Yes 2 ☐ No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence							ar (Specif	v)	
	ling After fune		27. Menner of Deeth 1 ☑Naturel 5 ☐ Panding 2 ☐ Accident investiga	tion	28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No					28d. Describe how injury occurred			
Division	or Att aftar d Direct I in by	Certification:	3 Suicida 6 Could not be detarmined 28e. Pieca of Injury - At homa, farm, street, factory, office building, etc. (Specify)						28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)				
	DIVI To the Hospital or Att within 24 hours aftar of To the Funeral Direct completely filled in by	edical									tha cause(s)		
	To the within To the	Σ	29b. Signeture and title of certifier		29c. License number M.E. D0003599			29d. Deta signed (Month, Day, Year) 03-22-99					
	.//\		John Es	.M.E.									
31	1014		30. Name and eddrass of person wi		1				.m. 63.5	0.3			
	-610	to	JOHN T. BULKELEY 31. Dete filed (Month, Dey, Year))8 PIN pistrar's Signe		ROAD, S	SALISBURY	MD 218	01			
	Sta Registr		MAR 23		Com	- 15	Spar	Ks					



Physician

1. Decedent's Name (First, Middle, Last)

Clare Marie Yeager

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

7. Age (In yrs. last birthday)

28

State of Maryland

1	Department of Health and Mental Hygiene	0	0	
	Cartificate of Death	-	0	

4b. City, Town, or Location of Death

Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Deys | Hours | Min. | (Month, Day, Year)

2. Date of Death

Month Day MARCH 22, 1999

February 22, 1971

4c. County of Death

ST. MARY's

MARCH 23, 1999

0969

3. Time of Death

Birthplace (State or Foreign Country)

Maryland

15:05 PM

0	Examine		4a Facility Neme (If not Institution ST . MARY S HO			ım <i>ber)</i>
	Funeral Director		5. Sociel Security Number 216–19–9837	6. Sex	M 2 ■ F	7. Ag
	the Meryland 28a-f show notified	tor	Usuel Residence of Decedent 10e. Stete 10b. County Maryland St. M	Mary	's	
	th with the 23s or 28	al Direc	10e. Street and Number 23360 Town Cree	ek D	rive	
020		by Funeral Director	11. Marital Stetus 1 Nevar Marriad 2 Marr 3 Widowed 4 Divorced	ried	2. Was Dec Armed F 1 Yas If Yes, G Yaar or I	orces?
5-0	72 ho	eted	15. Deceden (Specify only highs:			,
212	iene.	ошо	Elementery/Secondary (0-12)		College 6	(1-4or 5
iand	2 should be filed with end Mentel Hygiene en marked other that eumatic event, me	To Be Completed	17. Fether's Neme (First, Middle, Robert Pivec	Last)		
, Mary	s 1 and 2 should be filed f Health and Mentel Hyg item 27 le marked othe other treumatic event,		19e. Informent's Neme/Reletions Steven P. Yeage			usb
Baltimore, Maryiand 21215-0020	permit. Pages 1 end 2 sh Department of Health end Important: If item 27 ie m any injury or other treum page.		20e. Method of Disposition 1 Buriel 2 Cramation 4 Donetion 5 Other (S)		emovel from	State
Balt	permit. Departminents imports any inju		21. Signature of uneral line of F	SI	field	Jr
	Physician		23e. Pert1. Entar the disease, or shock, or heert feilure. List	complic only one	etions thet ceuse on	caused eech iii
	/Medical Examiner	PL	Immediate Ceuse (Finel disease or condition resulting in death)	a.	\mathcal{N}	Lu
		40				

10e. Stete 10b. County	10c. City, 1	Fown or Location			10d. Inside City Limits
Maryland St. Mary 10e. Street and Number 23360 Town Creek D 11. Marital Stetus 1 Nevar Marriad 2 Married	's Lex	ington Park			1 ☐ Yes 2 ■ No
10e. Street and Number		10f. Zip Code		10g. Citizen of W	hat Country?
23360 Town Creek D	rive	20653	And the second	United S	States
11. Marital Stetus 1 □ Nevar Marriad 2 ■ Married	12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 ■ No If Yes, Give	13. Was Decedent of It If Yas, specify Cub	hispanic Origin? (Specify Yes or Nan, Mexican, Puarto Rican, etc.) Specify:		- American Indian, k, White, etc.
3 Widowed 4 Divorced 15. Decedent's Educy (Specify only highest grade Elementery/Secondary (0-12)	Yaar or Dates:			Specily.	White
15. Decedent's Educ (Specify only highast grade Elementery/Secondary (0-12)		16a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Bu	siness/Industry
	5	Sales		Televisi	ion Production
17. Fether's Neme (First, Middle, Last) Robert Pivec			18. Mother's Name (First, Middle Elizabeth Emer		э)
19e. Informent's Neme/Reletionship (Type	pe, Print)	19b. Meiling Address (Street	and Number or Rural Route Num	ber, City or Town,	State, Zip Code)
Steven P. Yeager,	Husband 2	3360 Town Cre	ek Drive, Lexin	gton Park	c, MD 20653
20e. Method of Disposition 1 Buriel 2 Cremation 3 R 4 Donetion 5 Other (Specify)	emovel from State cem	e of Disposition (Name of letery, crematory or other pla			City or Town, Stete
21. Signature of Juneral Pervice Connect	field, Jr. M000	22. Neme end Addre Brinsfiel	d Funeral Home,	P.A.	
23e. Pert1. Entar the disease, or complishock, or heert feilure. List only on			.lywood Road, Le		Approximate
Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immedials cause. Enter Underbing	Multi Due to (or a	sa consequence of):	Lajuri	es	
Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or e	s a consequence of):	Tell.		
Cause (Disease of injury that initiated events resulting in death) Last Pert II. Other algnificant conditions con	Dua to (or as	s a consequence of):			
					f
Pert II. Other algnificant conditions con	tributing to death but not resultii	ng in the underlying cause gi			tribute to the cause of death? 3 Probably 4 Unknow
				as an autopsy formed?	24b. Were eutopsy findings available prior to completion of cause of death?
			15	Yes 2□No	1 DYes 2 No
25. Was case referred to medical			26. Place of Death (Check only	r one)	
examiner? 1 ☑ Yes 2 ☐ No	lospitel: 1 Inpatient 2 EF	VOutpatient 3 DOA Ot	her: 4 Nursing Home 5 Re		or (Specify)
27. Menner of Death 1 Neturel 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not be determined	3/22/99	Sb. Time of Injury Wo 10 o, ferm, street, fectory, office	Yes 2 No 28f. Location	e how injury occurred to the Street and Number own, State)	ed to vehicle ith Truck or or Aural Aoute Number,
27. Menner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Menner of Death 5 Pending invastigation 6 Could not be determined	ician: To the best of my knowle	edge, deeth occurred at the tine end/or investigation, in my of	me, date and place, and due to the opinion, deeth occurred et the time	e cause(s) and ma	nner as stated. and due to the cause(s)
29b. Signeture and title of cenifier	BALL	29c. Licens	se number	29d. Dete signed	i (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

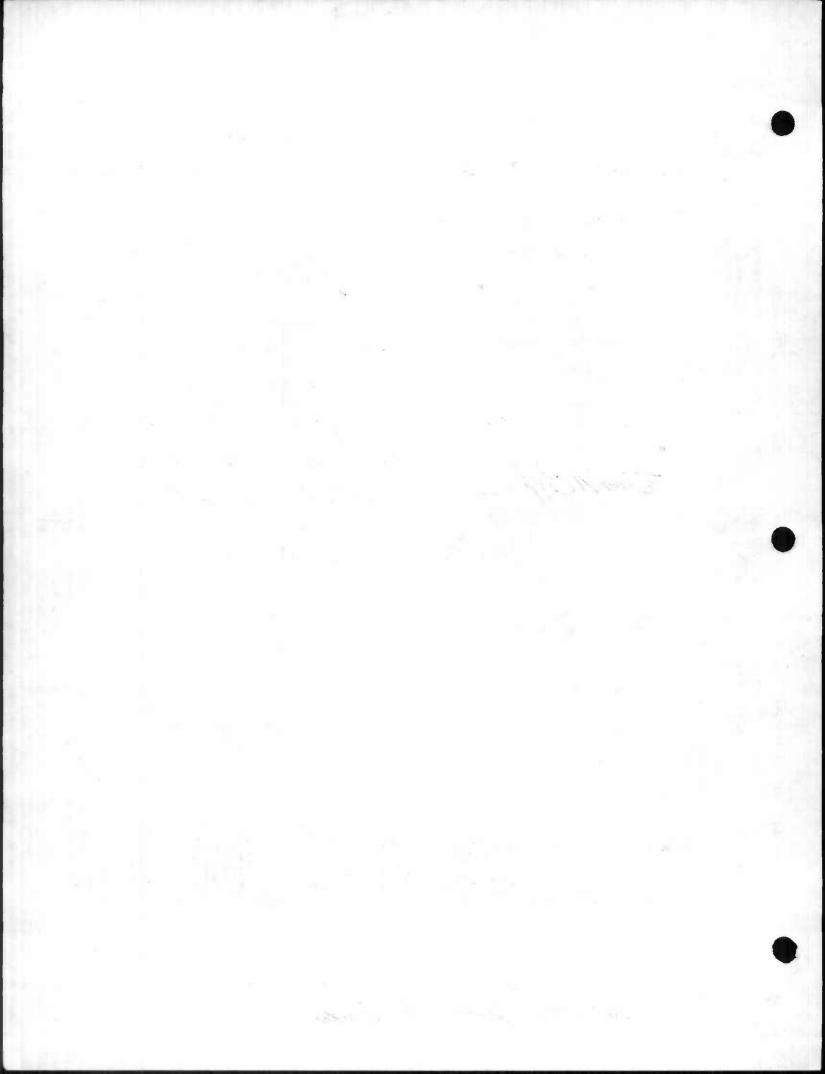
31. Dete filed Month, Day, Year)
MAR 2 5 1999

Division of Vital Records, P.O. Box 68760,

who completed cause of death (Item 23a) (Type, Print)

OCME

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nov 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Yeer **Physician** Ambrose Norris Apple, Sr. March 24, 1999 2119 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Sacred Heart Hospital If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

WV 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1XM 2□ F Months 87 Yrs. 217-10-1750 February 5, 1912 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours aftar death with the Manylan end of Health end Mentai thygiena.
Instit if Iem 27 Is marked outber than Instural, or itema 23a or 23a-1 show may or other traumatic event, the Medical Estimate must be notified any or other traumatic event, the Medical Estimate. 1X Yes 2□ No Director MD **Allegany** Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Rece - American Indian, Funeral 216 Piedmont Avenue 21502 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 XMarried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maryland State Roads Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Walter Apple Eunice Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret E. Apple/Wife P.O.Box 223 Hancock, Maryland 21750 20c. Location - City or Town, State 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremetion 3 Removal from State permit. Page Department of Important: If any injury or once. 03/28/99 Warfordsburg, PA Cedar Grove Christian 4 ☐ Donation 5 ☐ Other (Specify) Grove Funeral Home, P.A. 21 Signature of Funeral Gervice Licensee 141 W.Main St. Hancock, MD 21750-0368 caused the death. 23a. Part1. Enter the disease, or complex shock, or heert tailure. List only one Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final oyeans disease or condition resulting in deeth) Examiner Due to gras a consequence ot) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the buriel Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): attanding pl signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ò 24b. Were autopsy tindings evaileble prior to completion of cause ot death? 24a. Was en autopsy Completed s certificate hes b 1 ☐ Yes → No 1 □ Yes 2 □ No Division of Vital I or Attending Physician: after daath. Director: After this certifica funerel director. 25. Was case reterred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 200 No 2 Impatient 2 ER/Outpatlent 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident To the Hospital or Atterview within 24 hours after day To the Funeral Directo completaly filled in by the 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homlcide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. edical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 25. 30. Neme and eddress of person wito completed cause of death (Item 23a) (Type, Print)

Kent Avenue

625

1999

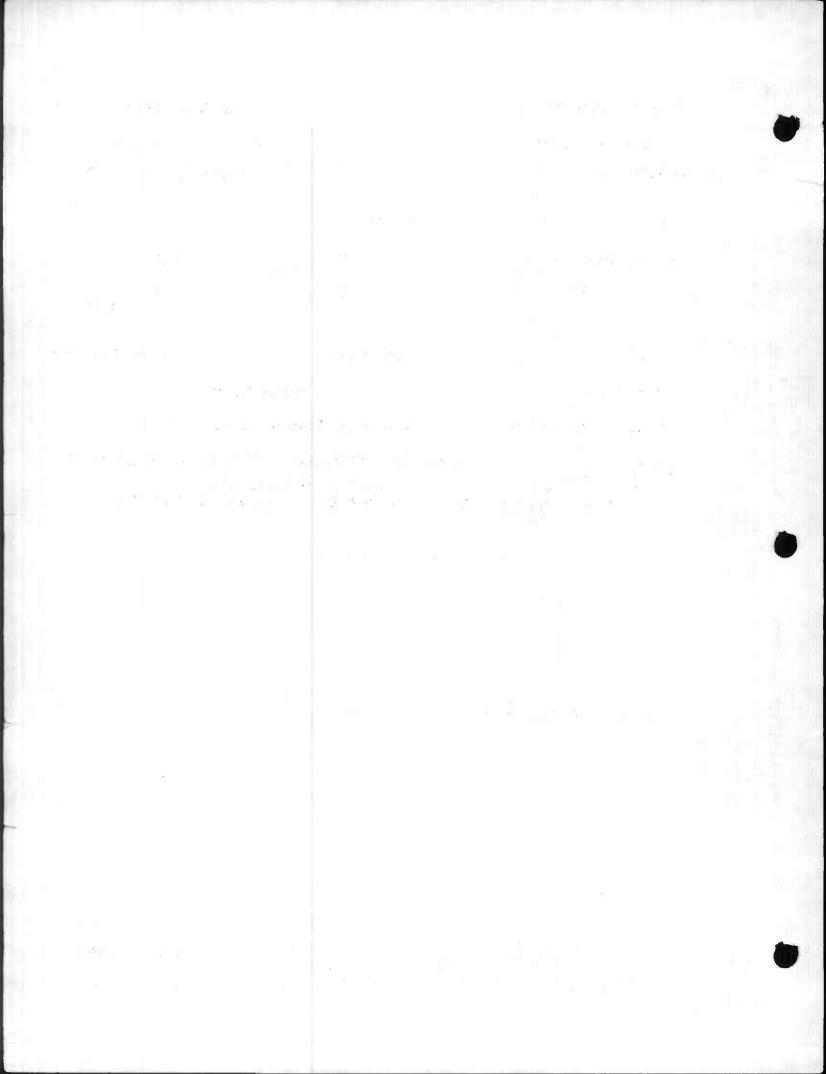
32. Registrar's Signature

umberland MD 21502

State Registrar Unil Gupta

APR

31. Date tiled (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Item#26 perPhyG770 4/8/99 EW Item 22 Per AB FilmG770 4-5-99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 **Physician** March 24, 10:40 P.M. Bowermaster Dora /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 220 Surrey Circle Drive Ft. Washington

ar | H Undar 24 Hrs. | 8. Date of the control of t Prince George's 5. Social Security Number If Under 1 Yaar Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☑ F Months Days Unknown Yrs. UNKNOWN Director UNKNOWN UNKNOWN Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Prince Georges Fort Washington Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours aftar death with Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or it injury or other traumatic event, the Medical Expanding must be in page. 20744 220 Surrey Circle Drive U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forcas? Unknown
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Unknown Black, White, atc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angella Bearden 220 Surrey Circle Dr. Ft. Washington, MD 20744 20a. Method of Disposition 20b. Piece of Disposition (Nama of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) In State Starten Affatton Food Board, 655 W. Baltimore Street George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Sant 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) Cardiac Arrythmia Examiner Due to (or as a consequenca of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): as esn ō signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Status Post Pneumonia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed Status Post Peptic Ulcer is certificata has director, page 2 1 Yes 2 No 1 TYPS 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 🖾 Residenca 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funaral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No Investigation 2 Accident within 24 hours after death To the Funeral Director: / completaly filled in by the 8 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide Hospital ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end dua to tha cause(s) and mannar statad. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 march 25 199 02635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd # 540 040 1 scataway

DHMH 16 Rev 6/95

State

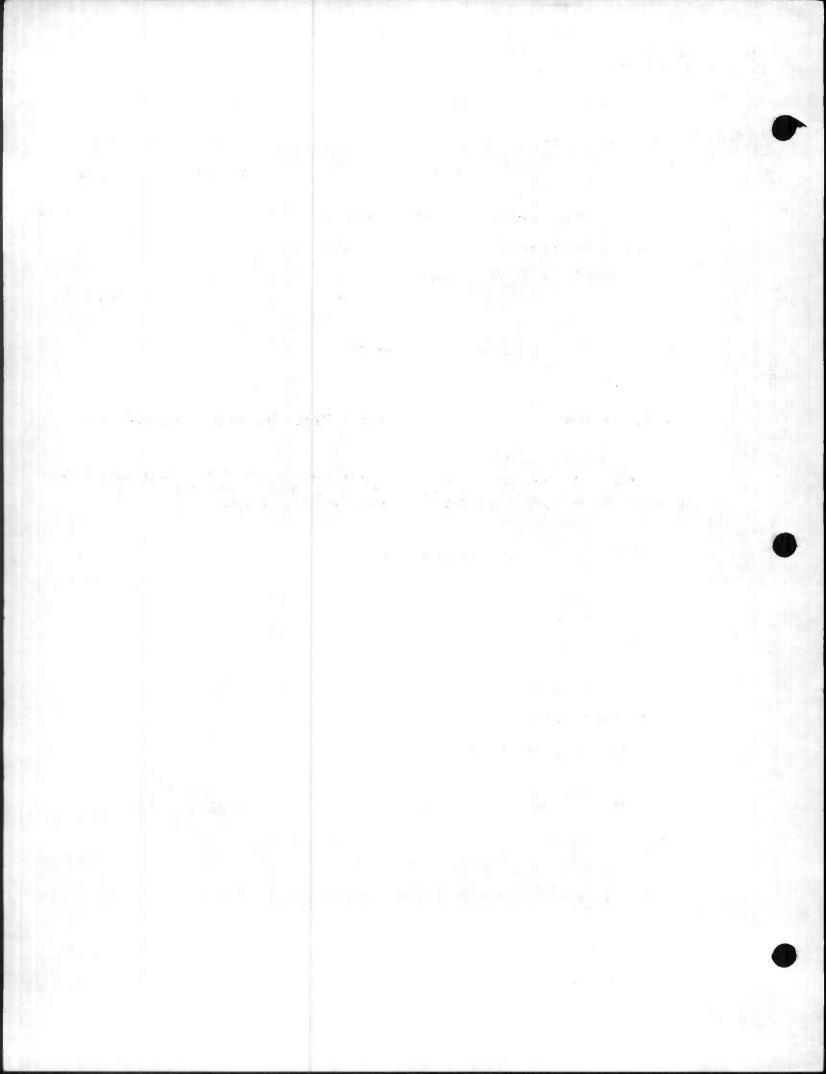
Registrar

31. Date filed (Month/ Day, Year)

APR 0 5 1999

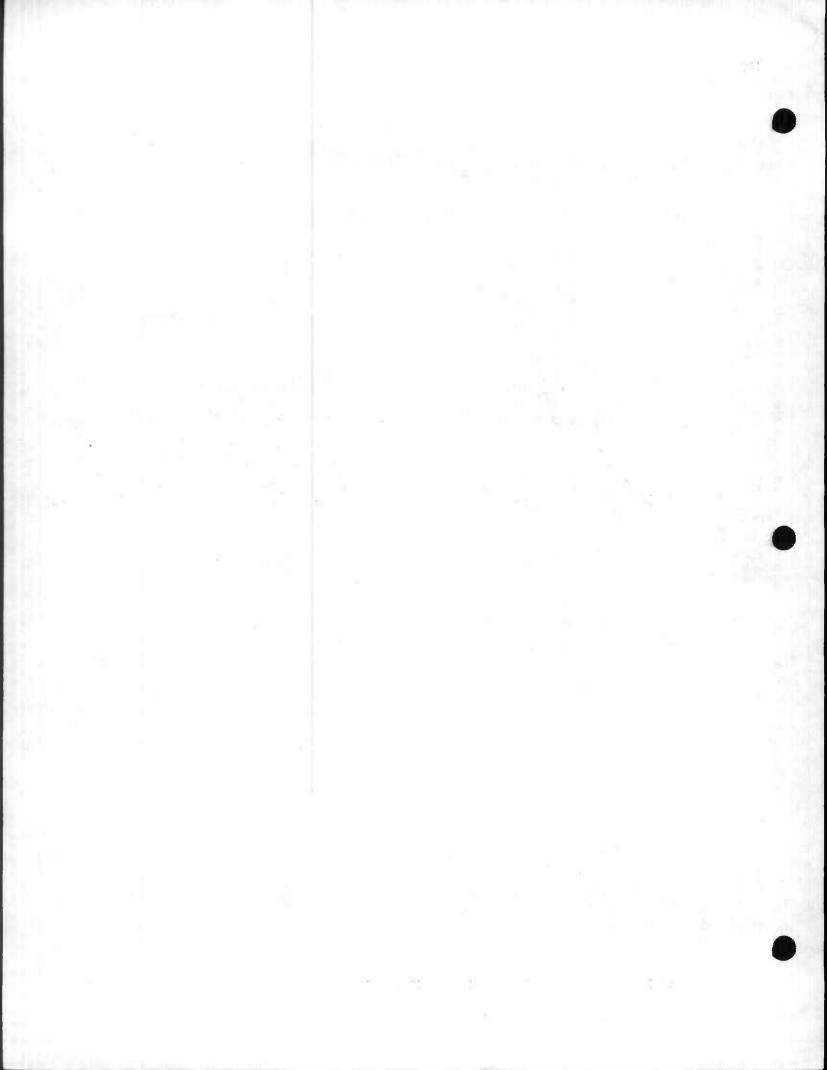
32. Begistrar's Signature

- marker



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible.

ITEMS. #	290	State of Mary , 30 PER MD G770 4-9-99 WR.		epartment of Heal Certificate of Dea) .	10972			
		1. Decement's Nama (First, Middla, Last)		Sertificate of Dec	2. De	Reg. No.	3. Time of Deeth			
Physicia /Medic		Elnora J. Butles		(/) = 0:	Apr	11 1,1999	1538			
Examin	er	As Facility Nama (If not institution, give street and number)	HOSF	Pital Pri	y, Town, or Location	of Death 4c. County	A Death			
Funeral Director		5 Social Security/Number 6. Sex 7. Age (N	n yrs. last birth		Inder 24 Hrs. 8. Da	te of Birth Pearl 35	9. Birthplace (State or Fereign			
pu a		Usual Rasidence of Decedent 10a. State 10b. County 10	Oc. City, Town	or Location		0,2,110	10d. Inside City Limits			
tha Marylar 28a-f ahow notified at	ctor	MD N/A	Ba/7	timore			1 Yas 2 No			
th with	ral Director	2700 N. Charles St	4	2/2/8	3	10g. Citizen of	What Country? A.			
9 2 2	by Funeral	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eye Armed Forcas? 1 Yes 2 No It Yas, Giva Year or Datas:	r in U,S.	13. Was Decedent of Hispan If Yes, specify Cuban, Mo 1 ☐ Yes 2 ☑ No Sp		os or No- atc.) 14. Rad Bla Specif	ce - American Indian, ck, White, etc.			
2 2 2	leted	15. Decedent's Education (Specify only highast grada completed)	. (Decedent's Usual Occupation Give kind of work done during lifa. DO NOT use retired)	most of working	16b. Kind of B	usiness/Industry			
21215- od within 72 or than "nat t, fr. Wedie	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	100	mestic		Home	3			
Maryland 2 d 2 should be liled th end Mental Hygis 7 la marked other traumatic avent, if	To Be C	8	8	e	17. Fathars Nama (First, Middle, Last), Vathaniel Folson		18/6	Mother's Nama (First Prona E	Middla, Maidan Sumar BUTIEN	na)
			19a. Informant's Name/Reletionship (Type, Print) NUCL LAPERS - SISTER	196.1	Meiling Address (Street and N	Number or Rural Rout.	Number, City or Town	State, Zip Code) D 2/0/2		
Baltimore, Nemit. Pages 1 end. Pepartment of Health moortent: if Item 27 iny Injury or other tr			20b. Place of I cemetery	Disposition (Nama of cremetory or other place)	Date	20c. Location	City or Town, State			
Baltimo	-	4 Donation 5 Oothar (Specify) 21. Signature of Facural Service Licerises	trou	(TUS TIPMON A2. Nama and Address of	[0] [7]0]	199 MI DU	105,110.			
Bait permit. Depart imports any injuices		· Varel W ford	_	3750 Frank	Inch tun	S Bolto	mb 21209			
		23a. Part Lenter by diverse, or complications that caused the shock, or hope failure. List only one cause on each line.	death. Do no	ot enter the mode of dying, su	ch es cardiac or respi	retory errest,	Approximata Intarval Batween Onset end Death			
/Medical Examiner		Immediate Pausa (Final diseasa or condition	Vegah	ive Bacteri	al Seps	ÌS	3/31.2 days			
	5	resulting in death) a	e to lar es e co	ensequence of):	ease	-	20 years			
60, be asserting iclan and burial-transit	Examine	U:		onsequence of):	T		10			
8760, cata be a	dical	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	es IV	ellitus, /	pel		luyears			
Box 68 tath certifica attending ph for use as the	Med	resulting in death) Last								
death certific	Physician	Completed by Physician/Me	Part II. Other significant conditions contributing to death but no	ot resulting in	the underlying causa given in	Part I 2	3b. Did tobacco use co	Intribute to the cause of death?		
ords, P.O. I requires that the designed by the a hould be detached if			Phys	Hypertension				1 □ Yes 2 Ø No	3 Probably 4 Unknown	
rds,	d by				24	la. Was an eutopsy	24b. Ware autopsy findings			
Records,	plet					performed?	available prior to completion of cause of death?			
of Vital Rec	Con	DF Was seen selected and the selected an				1 ☐ Yas 2 ♥ No	1 □ Yas 250 No			
Of Vital Physician: Titls certificater, per	To Be	25. Was casa refarred to medical examinar? 1 □ Yas 2 ☑ No Hospital: 1 ☑ Inpatient	2 ER/Outr	Othor	Place of Death (Chec	ck only one) ☐ Rasidance 6 ☐ Ott	ner (Specify)			
On of	:lon:	27. Mennar of Death 1 Natural 5 Pending (Month, Dey Ye	ear) 28b. Tir	ma of ury 28c. Injury et Work?	1	escribe how injury occur	rred			
Division of To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be	- At home, ferr	n, street, factory, office	28f. Lo	cation (Street and Numi by or Town, Stete)	ber or Rural Routa Number,			
Dital or purs after or filled in	S	29a. Certifier 1 Certifying Physician: To the best of m		death annumed at the time of						
To the Hospital of within 24 hours at To the Funeral D completely filled	edical	(Check only one) 2 Medicat Examiner: On the basis of axe and manner stated	amination and/	or investigation, in my opinior	a, death occurred at the	na tima, date and placa,	end due to the ceuse(s)			
To t To t		29b. Signeture end title of certifier N	n	AT 24	38946	April	od (Month, Day, Year)			
2		30. Name and addrass of person who completed causa of death								
Stat	e	VALERIE R. GREEN, MD: UNION MEMORIA 31. Data filed (Month, Day, Mar) 32. Registrar's		AL BALTIMORE, MD.						
Registra	ar	APR 6 1999	1	O. pporks						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey 15T 8.20PM BUTLER 1999 DOROTHY APRIL 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death SAMAritAN Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 1□ M A F 6017 Months 81 Yrs. 216-16-Aug 15, 1917 Usual Residence of Decadent 10a. Stata 10b. County 10c. City. Town or Location 10d. fnside City Limits 10 Yes 2 No BALLIMOTE Harylows 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? AVENUE 1445 Walker 21239 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 M No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) To a. Decements usual Occupation
(Giva kind of work done during most of working life, DO NOT use retired)

SECURITY GRAPD Boys Home Elementary/Secondary (0-12) College (1-4or 5+) 6th gredi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ButLER KANDOLPH 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 43 SHERIDAN AUG BAlhum, Red 21239 GREAT NIECE TRUCES MOHORN 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4-6-99 AKBUTUS MEMORIAL AFBUTU, 4 ☐ Donation 5 ☐ Other (Specify) Forte 22. Name end Address of Facility CHATHM-HARRIFA 21. Signature of Funeral Servica Ligary BAHO REISTELLHUM RUMD BAHOMING FILD SIDIE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 2 PAYS Due to (or es e consequence of) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as e consequenca of) Part tt. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part f. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospitat: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Directo

Funeral

þ

Completed

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Exercise main be notified at

the Maryland

72 hours after death

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any injury or other traumatic event, phose.

altimore, Maryland 21215-0020

ed by the attanding physician and detached for use as the burial-transit signed by t been s has certificate

Physician/Medical Examiner by Completed Be 2 Certification:

within 24 hours aftar death.

To the Funeral Director: After this certific complataly filled in by the funeral director, or Attending

The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. Physician:

Registra

State

edical

FRANCIS KNASHIE ATTIOGBE GOOD SAMARUTAN HOSPITAL OF MARYLAND INC 31. Dete filed (Month, Day, Year) APR 0 6 1999

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 PNatural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

32. Registrar's Signature Sereva

30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MEDICAL DOCTOR

28a. Place of tnjury - At homa, farm, straat, factory, office building, etc. (Specify)

1 Yes 2 No

00052277

1 Certifying Physicfan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner es stated.

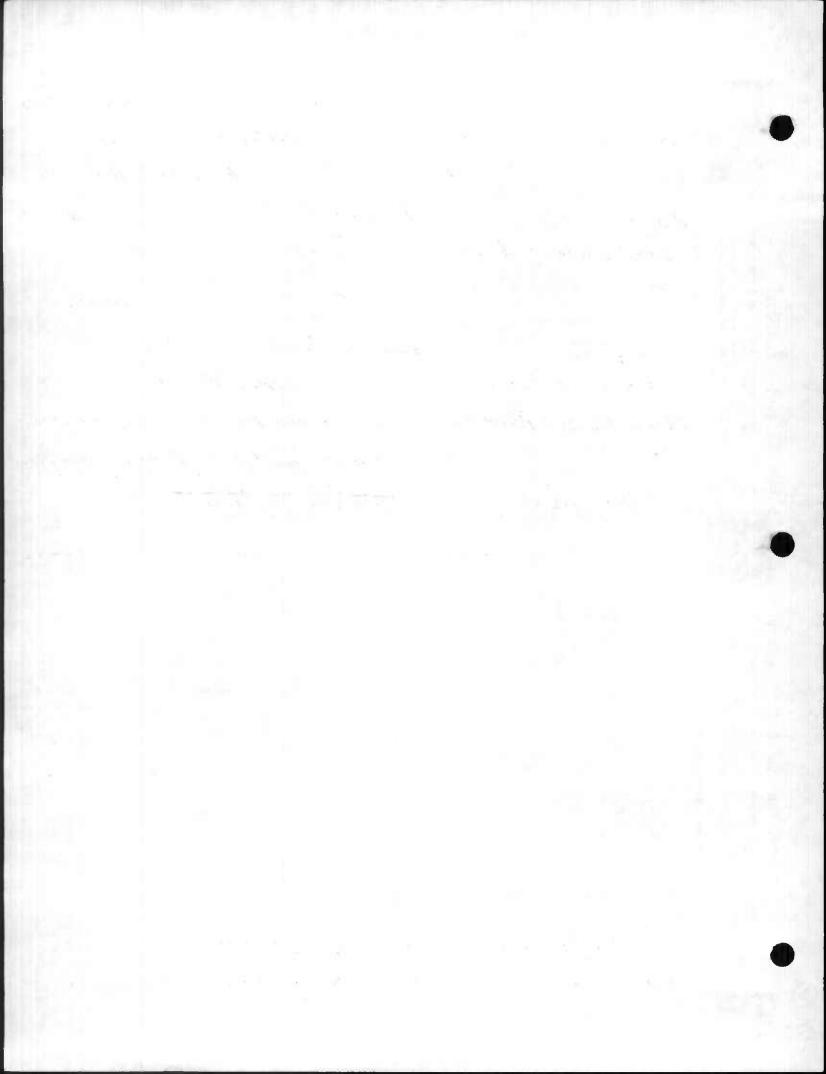
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

APRIL

29d. Date signad (Month, Day, Year)

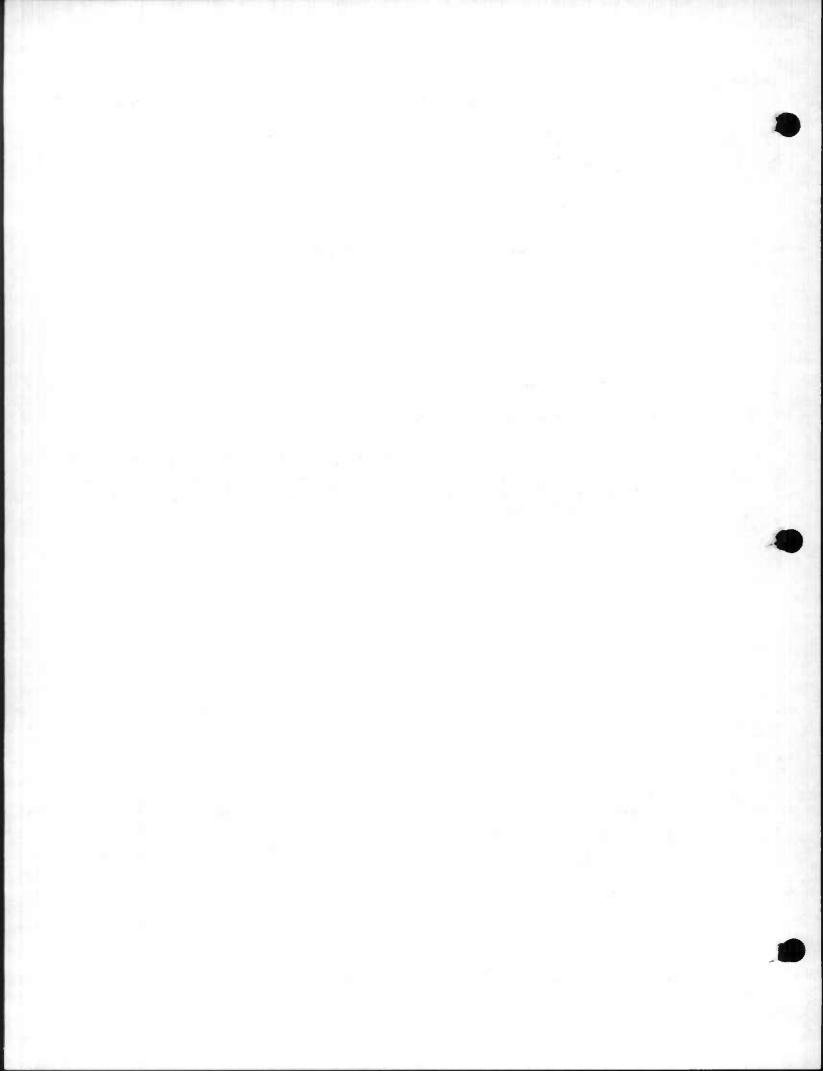


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 1999 Margaret Mary Baranowski April 3:38pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 718 Cherry Hill Road Street Harford 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, JAN 3, 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 → F 218-07-7574 Yrs. 78 Director Maryland Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show frems 23a or 28a-f shov iner must be notified at MD Harford Street Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 718 Cherry Hill Road 21154 Completed by Funeral USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, traumatic evant, the Medical Examiner Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 6 1 ☐ Yas 2 ☐ No Specify: White 3 Widowed 4 Divorced natural', 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry el Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic Maryland 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Peges 1 and 2 should be fill ment of Health end Mentel Hant: If item 27 is marked oth jury or other traumatic evan James J. Janowiak Anna Novak 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Catherine M. Fuller/daughter 718 Cherry Hill Rd. Street, MD Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 【XCremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or once. Metro Crematory, Inc. 04/06/99 Baltimore, MD 21. Signeture of Funeral Sarvice License Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 212 23a. Part1. Entiar the disease, or complications that cause shock, or heart failure. List only one ceuse on each McDonald or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, let only one cause on each line. **Physician** /Medical Immediate Ceusa (Final COPD 3715 disease or condition resulting in deeth) **Examiner** Due to (or es a consaquence ot): or Attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the ettending physician end Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseesa or Injury that initiated evants resulting in death) Last Due to (or es e consaguence of) Box 68760, ettending physician Physician/Medical Due to (or as a consequence of) been signed by the etter should be deteched for P.O. Pert il. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Squamous cell CA Division of Vital Records. þ Completed 24b. Were eutopsy findings eveileble prior to complation of ceuse ot daeth? 24a. Was en eutopsy 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No Be 25. Wes casa referred to medical 26. Pleca of Daath (Check only one) exeminer? 2 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Daeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accidant filled in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) 4 Homicida To the Hospital within 24 hours or To the Funeral Completely filled edicai Cartifying Physicien: To the best of my knowledge, daath occurred et the tima, deta and place, and due to tha ceusa(s) and mannar as steted.

Madical Examiner: On the basis of exemination and/or investigetion, in my opinion, death occurred et tha tima, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 120 928 416199 30. Name and eddrass of person who completed ceuse of daath (Itam 23e) (Type, Print) Charles Zerez, M.D. 2014 Tollgate Rd. Suite 200 Bel Air, MD 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar APR 6 1999 Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Day Month Year **Physician** 00 pm 1999 Blakney March 31 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Levindale N/H If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 06 09 39 Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 10M 20F 06 59 227-50-2307 Director V.A. Usual Rasidance of Decedant 10e. Steta 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director 288-7 Baltimore MD NA 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 238 1017 North Fulton Ave U.S.A. Funeral 21217 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 🕱 No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. Stems 1 Nevar Married Married 'natural', or Baltimore, Maryland 21215-0020 1 Yas 2X No Specify: Specify: Black À Yaar or Datas: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) Housewife Home 11th grade 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) 96 h and Mental I and 2 should be Allen Lovelace Cennie Bradley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a important: if Nem 27 is any injury or 21217 Roger Blakney-Husband 1017 North Fulton Ave, Baltimore Md 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Pages 1 1 🛮 Burial 2 ☐ Cremetion 3 ☐ Ramoval from Steta 4/6/99 Baltimore Co., Md 4 □ Donation 5 □ Othar (Specify) VoshellMem Gardens 21. Signature of Furgett Service Licensee 22. Name end Address of Facility March F/H West 4300 Wabash AVe, 21215 Baltimore Md 23a. Part1. Entar the disease, or complication. that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart triture. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition resulting in deeth) cardio-pulmonory Examiner Due to (or as a consequence of): Examine Congestive heart physician end s the burial-trans Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in deeth) Last Dua to (or as a consequence of): disease Cardiomyspath Box 68760 artery dihoted Physician/Medical Due to (or as a consequence of): Chronic Part II. Other elgniflcant conditions contributing to death but not rasulting in the underlying cause given in Part I.

Hepato cellular dy stunctum 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown detubit by Records, 24b. Were autopsy tindings aveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No dependent Vital Insulin 25. Was casa ratarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitel: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27 Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 5 Panding invastigation Division 1-BNeture 1 Tas 2 No death. 2 Accidant Director: 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 ☐ Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

Consul

31. Dete filed (Month, Day, Year)

w.

0 6 1999

30. Nama and addrass of person who completed cabsa of death (Item 23a) (Type, Print)

Belvedon

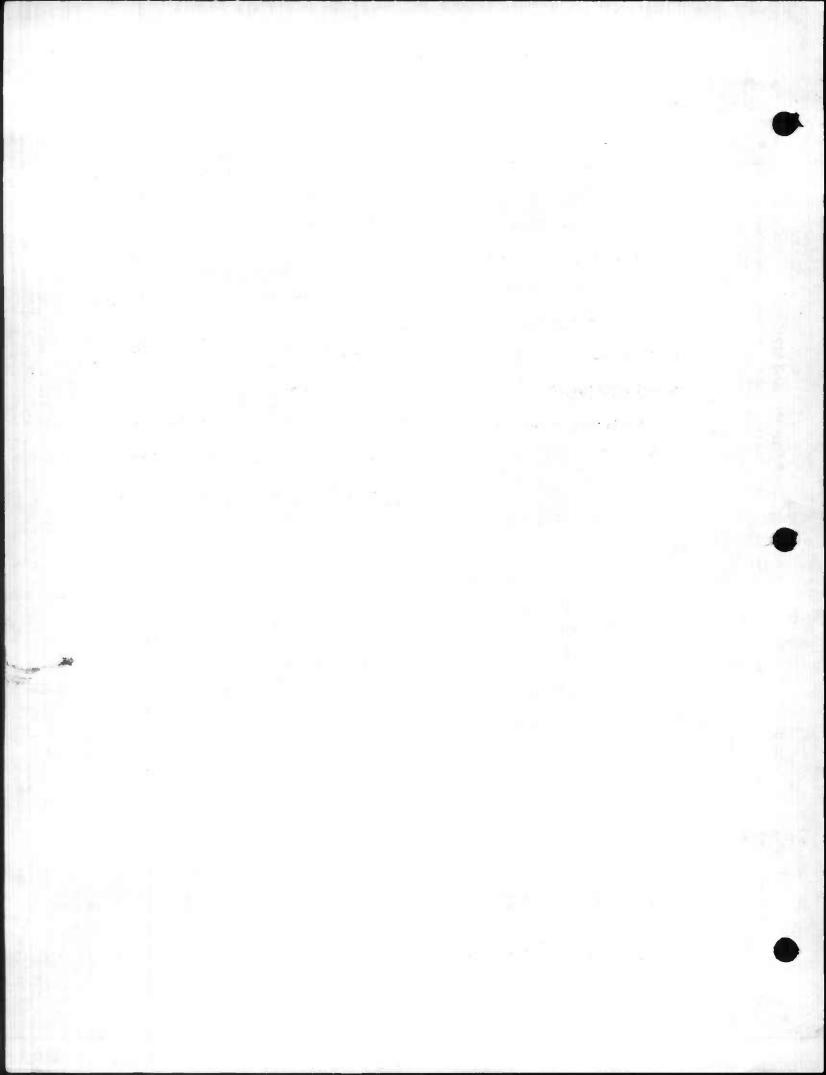
32. Registrar's Signatura

D: 44907

CONSUELO

/mril

ALVANEZ, ms



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death MARCH 31, 1999 John 11:16 AM Otis Brooks 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5 Social Security Number 6. Sex 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) Months 1 XM 2 ☐ F Deys Hours 226-52-6597 58 Yrs. V.A. 07 25 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2502 1/2 Ruscombe Lane U.S.A.

14. Rece - American fndien,
Black, White, etc. 21215 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Vendor Cigarette Company 10th grade na 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Alease Veney John Brooks 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Gloria Brooks-Wife 2502 1/2 Ruscombe Lane, Baltimore Md 21215 20b. Place of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Mulberry Bap Cemetery 4/5/99 Farnham, V.A. 21. Signeture of Fun and Service Licensee 22. Neme end Address of Fecility
March F/H West 4300 Wabash Ave, Baltimore Md ala 21215 in i. Ent-r the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth ADULT RESPIRATORY DISTRESS SYNDROME Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): BRONCHOPNEUMONIA Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or es e consequença of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown LEFT VENTRICULAR HYPERTROPHY 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 11√2 Yes 2 No 1 ¥ Yes 2□ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

permit. Peges 1 end 2 sh Depertment of Health and Important: If Item 27 is m any injury or other traum pance.

Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Exercites must be notified at

2 should be filed within 72 hours after of and Mentel Hygiene.
Is marked other than "natural", or item

altimore, Maryland 21215-0020

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ettending physician end for use as the burial-trans 38 detached 100 signed by t page 2 hes

Physician/Medical

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To

Certification:

edicai

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homloide

(Check only one)

certificate be executed certificate director. this funeral After

Box 68760

Division of Vital Records, or Attending Physician: s efter deeth. filled in by Hospital 24 hours completely To the Vithin 2

> State Registrar

31. Dete filed (Month, Dey, Year) 0 6 1999

29b. Signeture end title of certifier

5 Pending

Investigation

6 Could not be determined



30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner steled.

29c. License number

D 28244

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

3-31-99

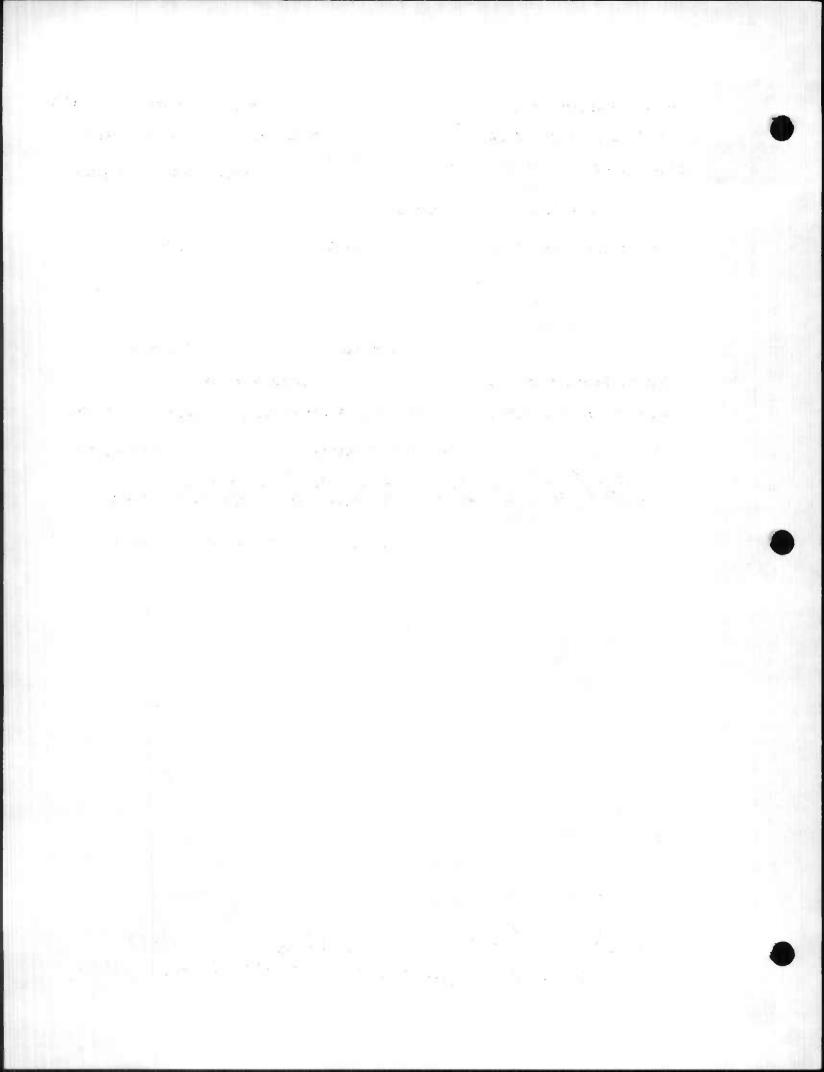
29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 99 10977

	Item: 2, per M.D G-700 4/13/99 reb Certificate of Death	Re	g. No.	. 0 5 7 .				
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	April 4,199	3. Time of Deeth				
/Medical	Nadine Shirley Brown	arch 4,	1999	8:50am				
Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Lo 4co Admiral Drive #202 Annapolis	ocation of Death	Anne Ar	undel				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign				
Director	Usual Residence of Decedent	Feb.2,19	30 Mar	yland				
the Maryland 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1				
Office deeth with the Maryland free fears 23s or 28s-f show when must be notified at Funerral Director	10e. Street end Number 605 Admiral Drive #202 10f. Zip Code 21401		g. Citizen of What C	Country?				
ozo urs aftar af, or its Examine	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W					
72 hours "natural; ad call Ex	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ing 1	6b. Kind of Business	s/Industry				
3 within jiene.	(Specify only highest grade completed) Elementery/Secondary (0-12) 12 (Give kind of work done during most of work life. DO NOT use retired) Underwriter		nsurance					
be filed tel Hygied d other event,	17. Father's Neme (First, Middle, Last)		laiden Sumame)					
should be marked o marked o marked o To Be	Charles Joseph Cammarata Marie To	uchard						
Mar nd 2 sh lith end tr is m	19a. Informant's Name/Relationship (Type, Print) Lewis E. Brown - Husband 19b. Mailing Address (Street and Number or Run 605 Admiral Drive #202			Zip Code) 21401				
5 5 5	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)		Oc. Location - City o					
Baltimo permit. Page Department of Important: if any injury or once.	21. Signature of Euperay Service Licensee 22. Name and Address of Facility Hardesty Funeral Ho 12 RIdgely Ave. Ann.							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feilure. List only one ceuse on each line.	or respiratory erre	11D 21401 st,	Approximate tntervai Between				
Physician // // // // // // // // // // // // //	Immediate Cause (Final disease or condition Adenocavi noma of Univ		Onset and Death					
Examiner	resulting in deeth) Due to (or es a consequence of):	•						
68760, ficete be assecuted physician end is the burial-transit edical Examiner	Sequentially list conditions, Due to (or as a consequence of):	Due to (or as a consequence of):						
68760, rifficete be axecuted no physician end es the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):							
- 00								
Geath cer death cer e ettendir od for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.	23h Did tok	nacco uea contribu	te to the cause of death				
P.O. hat the bd by the detache	Part ii. Other significant conditions contributing to death out not resulting in the underlying cause given in Part i.	1 T Ye		Probably 4 Unknow				
cords, requires to requires to should be should be letted by		24a. Wes an		. Were eutopsy findings available prior to completion of ceuse of death?				
0) 6 5 7		1 ☐ Ye	s ALINO	1 ☐ Yes 2 ☐ No				
f Vital Roysician: The last certificate had director, page			9	707 20110				
of Vita Physician: this certific ral director,		1	nce 6 ☐Other (Sp	ecify)				
		28d. Describe ho	w injury occurred					
Division o To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director. After th completely filled in by the funeral Medical Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work / 2 Accident Investigation M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Displant or ours eft. Weral Direction of the contract of the c	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,			as stated.				
• Hose Pur Peter	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.							
To the Youthing To the Comp		29	Od. Date signed (Mor	nth, Day, Year)				
6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C+1) CU+ F COON (CLA 144.0), GOO BEST GOT	Anv	rapolis l	Md.				
State	31. Date filed (Month, Day, Year). 32. Registrar's Signeture	1 }'		*				



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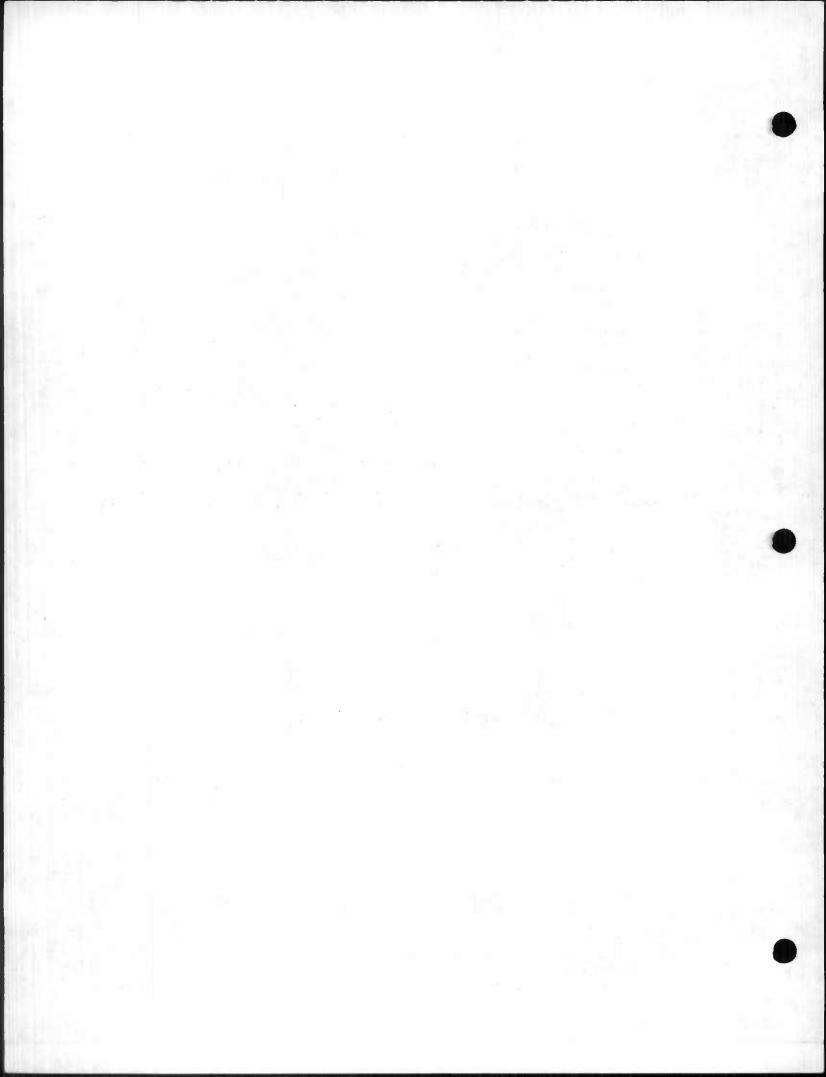
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey 1 1999 **Physician** KATHARINE GARRETT BAINBRIDGE MARCH 31 1:00am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDER CARE AT BRIGHTWOOD LUTHERVILLE BALTIMORE Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) MARYLAND Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10M 2 F Director 84 Usual Residence of Deceden the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show must be notified at 1 ☐ Yes 2 No Director BALTIMORE LUTHERVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Nerne 23a or 515 BRIGHTFIELD RD. 21093 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after Hygiene. After then "netural", or the 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Nem 27 is marked other tha any Injury or other traumatic - other tha 12YRS HOUSEWIFE HOMEMAKER 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumemet Be ROBERT GARRETT KATHARINE JOHNSON 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN S. BAINBRIDGE JR(SON) 1914 GEIST RD. GLYNDON, MD. 21071. 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY04/01/99 BALTO., MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 101 Allon 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) attending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records, g 24b. Were eutopsy findings evailable prior to Completed 24a. Wes en autopsy performed? completion of cause of deeth? cartificate has t 1 Yes 210No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this Aftar this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: / 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletally filled in by Medical 29a. Certified 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) end menner es stated. (Check only ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Dey, Year) Cyn M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL G. SAPIR M/D 10755 FALLS RD. LUTHERVILLE, MD. 21093. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death 130 **Physician** 1999 Melvin J. Buttner march /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) Examiner Mariner Nursing Home of BelAir Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Harford if Under 1 Year 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Yrs. 216-20-2255 Director Jan. 13, 1926 Baltimore, Maryland Usual Residence of Decedent Pagas 1 and 2 should be filed within 72 hours aftar daath with the Maryland nant of Health and Mental Hygiene.

Int: If Hem 27 is marked other than "naturel; or Hems 23s or 28s-f show ury or other treumetic event, the Hedical Examine must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Harford Forest Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21050 1310 Turnbridge Road UalU

12. Was Decedent Ever in U,S.

Armed Forces?

1 Dayes 2 □ No Navy

If Yes, Give

Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 yrs. n/a Real Estate Appraiser Real Estate Industry 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) John George Buttner Vernona L. Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia B. Buttner (Wife) 1310 Turnbridge Road Forest Hill, MD. 21050 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4/3/99 Baltimore, Maryland 22. Name and Address of Facility E.F.Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

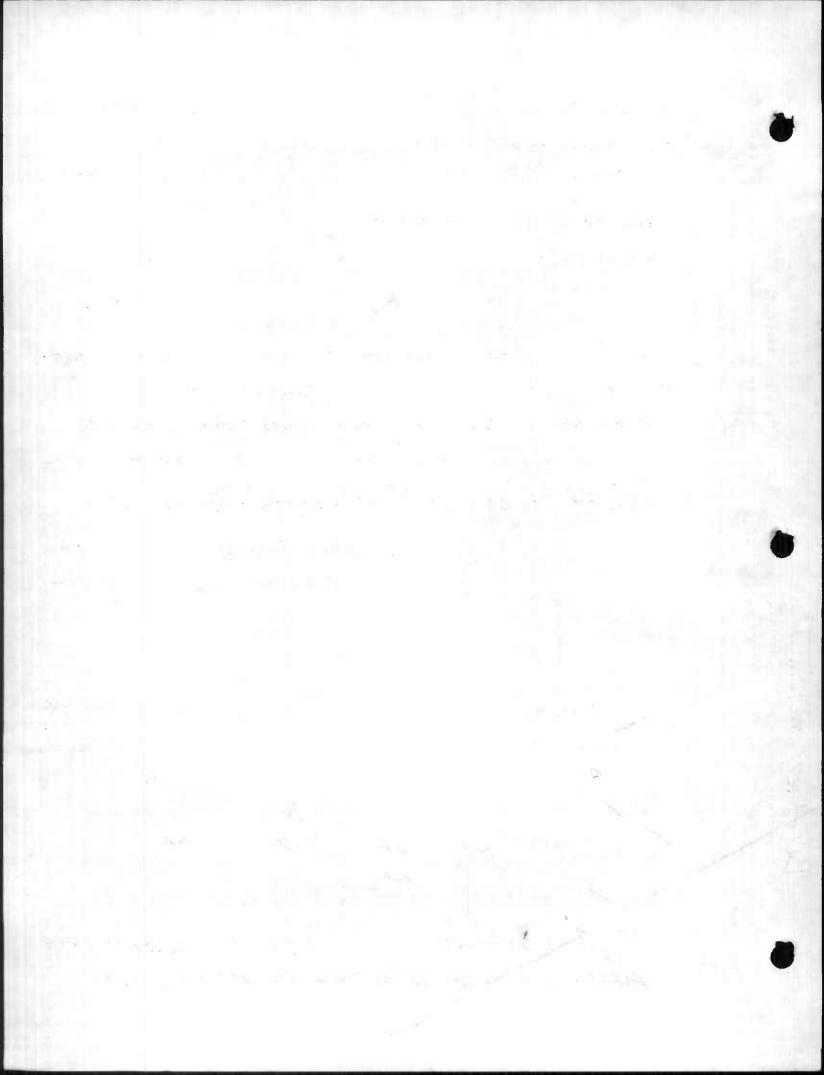
Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximete Interval Between Onset end Death Physician /Medicai Immediate Cause (Final disease or condition resulting in death) 1 MOS Examiner KPIRATION / MUS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 1) i ABetes à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Partur sons 24e. Wes an autopsy performed? Completed ALZ HUMENS 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Dev Year) 1 Natural
2 Accident 5 Pending NA NA 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier MARCH 31, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRED SPANIS 615 W. MKPHAIL BUL ACR MD 21014 31. Dete filed (Month, Day, Year) 32. Registrar's Signature_... Registrar

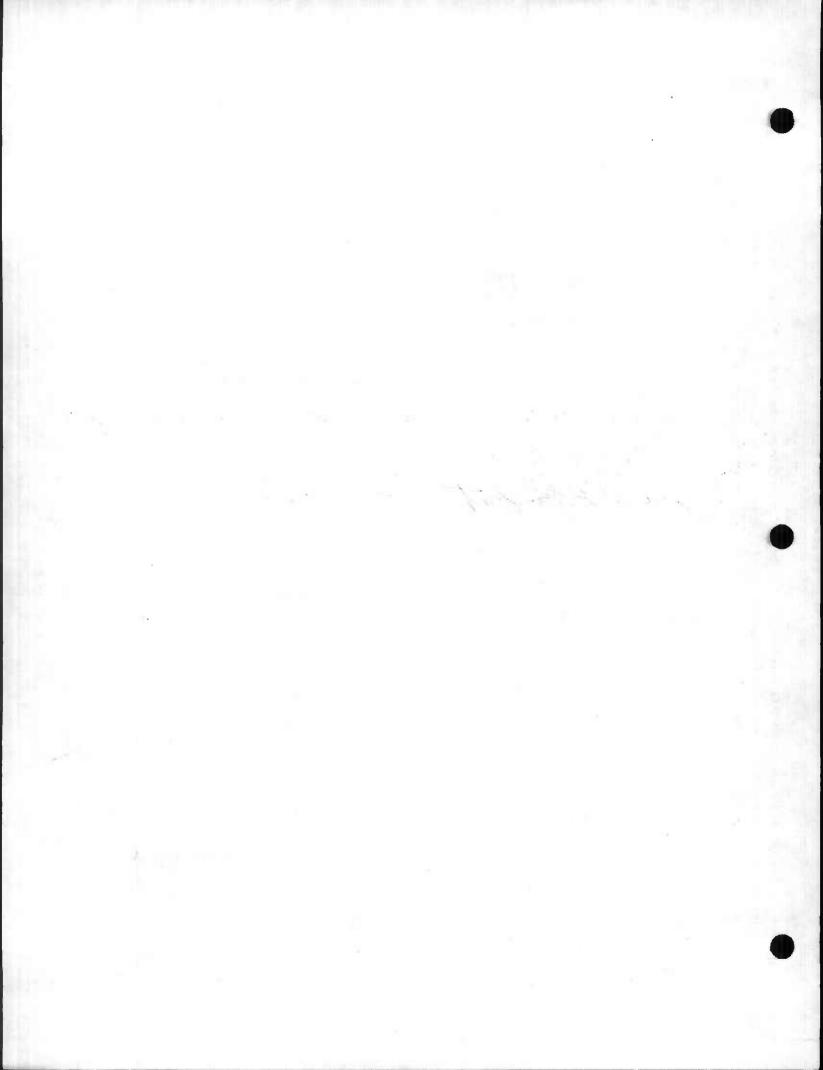


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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 3. Time of Death 2. Deta of Death **Physician** Crawforg Harold 121 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Culumsia Warsing OWGL HOM & If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplaca (Stete or Foreign Country) **Funeral** Year) 1917 West Virginia Days Hours Months 1₩ 2□ F 213-20-4057 Yrs. Nov. Director Usuel Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at Maryland 1 Yes 2 No Director Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6334 Cedar Lane 21044 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Statue 14. Race - American Indien. Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after in the Health and Mental Hygiena. 1 XYes 2 No If Yes, Give Year or Detes:1944-45 1 ☐ Navar Married 2K Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White A 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Installer Construction 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Lest) Be Cleo Sammons Charles Thomas Crawford 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Margaret Crawford/wife 10301 Wesleigh Drive, Columbia, Maryland 21046 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State Important: If H any Injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Ø Other (Specify) In State 21. Signature of Funeral Servica Licensee Joseph B. Van State Anatomy Board, 655 W. Baltimore Street Sant Baltimore, Maryland 21201 or the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician arkinsons disease /Medical Immediate Cause (Final C91 disease or condition resulting in death) Examiner Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 that the death certificate be Physician/Medical Due to (or as a consequence of) 2 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown ementis Division of Vital Records. à 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: Be 25. Wes case referred to medical exeminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth Medical Certification: 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neture 5 Pending Investigation death. 1 Yes 2 No To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homleide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person ye impleted cause of deeth (Item 23e) (Type, Print) Ridge Rel Columbia Med 21045 HICKOV 31. Data filed (Month, Dey, Yeer) 32. Registrar's Signature State APR 0 6 1999

Registrar **DHMH 16 Rev 6/95**



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Maryland

Saltimore,

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time th Month 30, Melvin Marvin Carneal 1999 3:35 m.m. March 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1⊠M 2□F Months Deys Hours 65 Yrs. January 3,1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? 7413 Chesapeake Avenue 21219 United States 12. Was Decedent Ever In U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) city government Elementary/Secondery (0-12) College (1-4or 5+) library superintendant of maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Thomas Marvin Carneal Virginia Pickett 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janet L. Carneal - wife 7413 Chesapeake Avenue, Edgemere, Maryland 21219 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/2/99 Baltimore, Maryland Loudon Park Cemetery Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 3620 Wilkens Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or comblicati shock, or heart feilure. List only one c lications that coused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death **PANCREATIC CANCER** Due to (or as a consequence of): Due to (or as a consequence of).

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f

the Medical Examiner must be

b

Herne 23a

6

"natural".

marked other

Department of Health and Important: If item 27 is m.

2 should be f and Mental F

the Marylant

5. Social Security Number

215-28-9438

Maryland

11 Marital Status

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

10e. Stete

Director

Funeral

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Completed

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2

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Physician/Medicai by Completed

Be

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Certification:

Medical

29a. Certifier

buriel-transit physician s the buriel 8 esn ō s been signed by t should be datach page 2 certificate has After this Attending

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fun

0 State

Registrar

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last 25. Was case referred to medicel

Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

1 ☐ Yes 2 ☐ No 24a. Wes an autopsy

3 Probably 4 Unknown

23b. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

1 Yes 2K No 26. Plece of Deeth (Check only one)

HOSPICE

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No

2 Accident 3 Suicide 6 Could not be 4 Homicide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

30. 95.

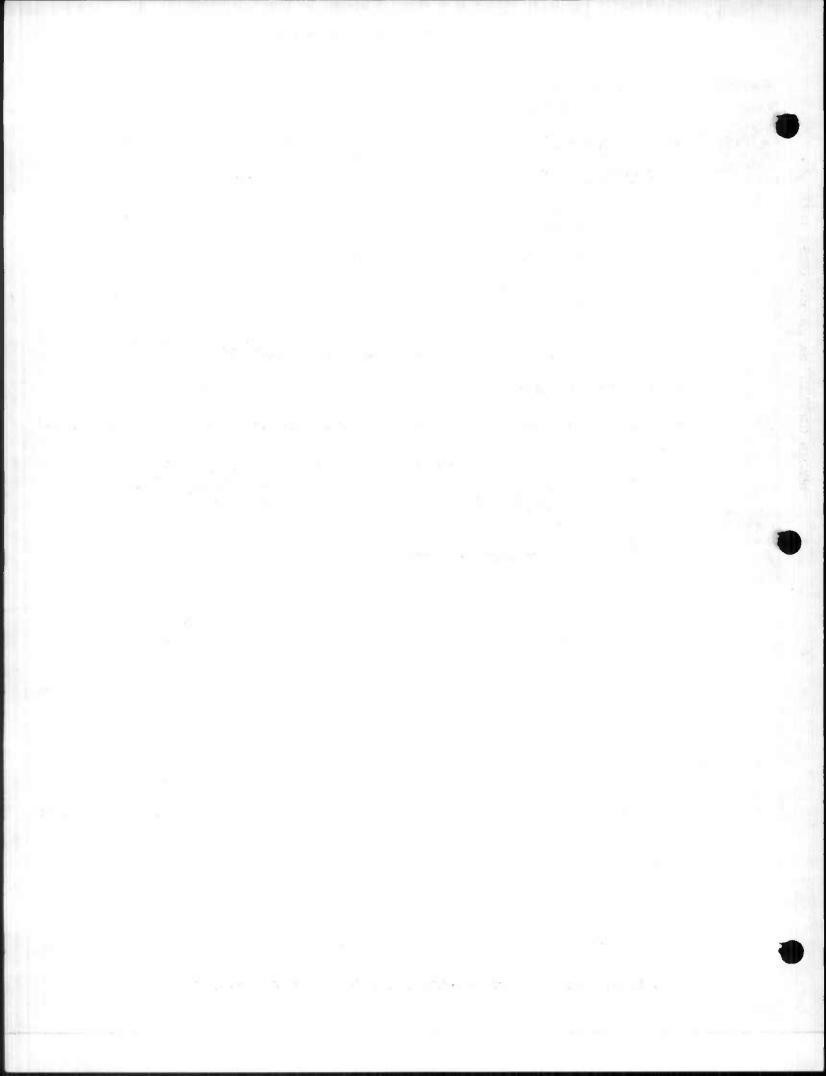
10x Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and tit certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Skhode

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) 06 1999 32. Registrar's Signature



filed within 72 hours effer deeth with the Meryland Hyglene. Hyglene. r than "natural", or han 21215-0020 i. Peges 1 and 2 should be filed w tment of Health and Mental Hygler tant: If Nam 27 is marked other th jury or other traumatic event, that Maryland Baltimore, Department

Carrol

largaret

Physician /Medical Examiner

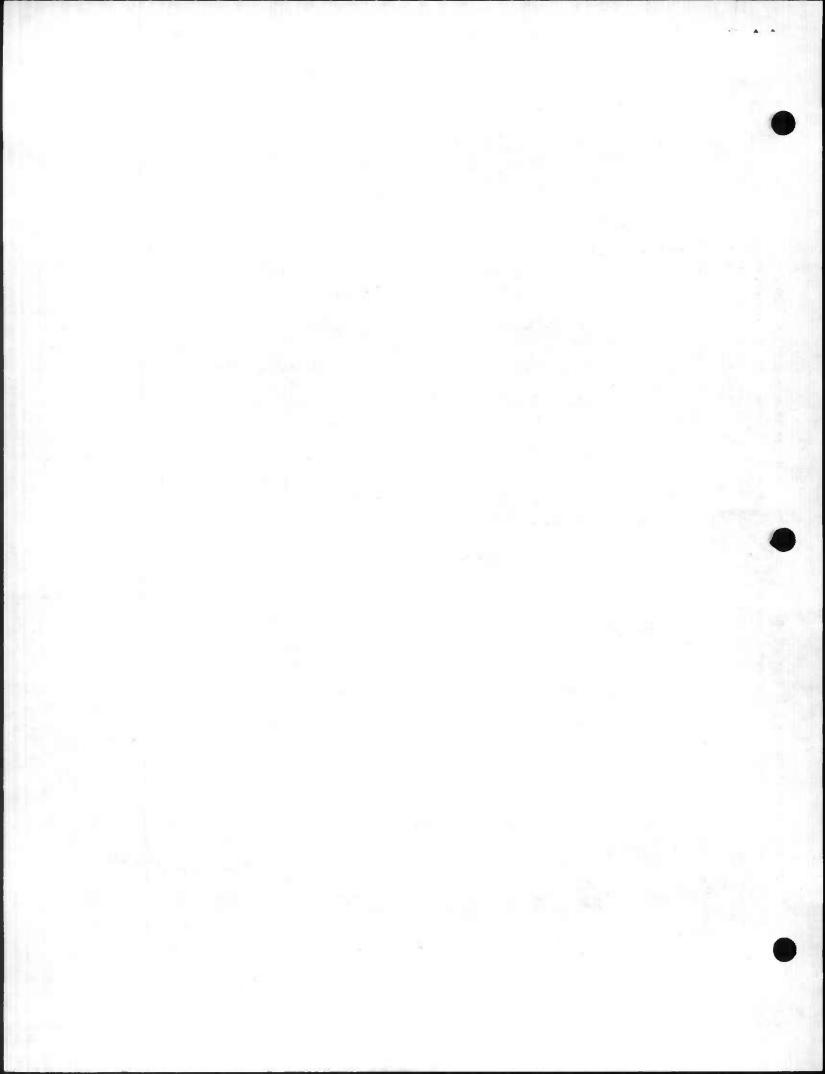
I or Attending Physicien: The lew requires that the death certificate be executed effer death.

Director: After this certificate has been signed by the attending physicien and Division To the Hospital of within 24 hours of To the Funerel D completely filled it

P.O. Box 68760, Records, of Vital

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 4, 1999 Margaret P. Carroll April 2:00pm 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare-Hamilton Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 🕅 F 84 218-30-5790 0/05/1914 Baltimore, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notfied at N/A YOYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3318 Bayonne Avenue 21214 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried Specify: White 1 Yes 2 No Specify: þ 3 ℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Jones Anna Sigrist 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dolores Anna Fritz/niece 717 Maiden Choice Lane-Apt T-17, Baltimore, MD21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Dother (Specify) 04/07/99 Baltimore, Maryland Moreland Memorial Park 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 5305 Harford Road, Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) neumma Due to (or as a consequence of): buriel-transh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical å Due to (or as a consequence of): for use es signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed by 24a. Wes an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 2 3 No 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of persoq who completed cause of death (Item 23a) (Type, Print) Bellow 1H3mpm Belen 9618 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10e.19b per FHG770 4/6/99 EW 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 1999 2:31 Nora Willie Collins 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Saint Joseph Medical Center Towson 5 Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28 1920 9. Birthplace (State or Foreign 6 Sex Months Days 1 □ M 280 F Hours 408-32-6975 78 Virginia Usuai Residence of Decedent 10b County 10c City Town or Location 10d Inside City Limits MD. Baltimore Towson 1 Type 200 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 915 East Seminary Rd. Ave. 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Tes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) Etementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph P. Adams Daisy Pannell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 915 East Seminary Rd. Towson, MD. 21286 Mr. Gary W. Collins/ Son 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State 20a. Method of Disposition etery, crematory or other piece) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Lake View Cemetery 4-9-99 Sykesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility RUCK TOWSON FUNEral Home, Inc. 1050 York Rd, . Towson, MD. 21204 tions thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, cause on each line. Approximate Intervel Between Onset and Death 8 YEARS EXTENSIVE LARGE CELL LYMPHOMA Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of) Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy

1 ☐ Yes 2 No

1999

1 Yes

28d. Describe how injury occurred

MD

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

21204

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Death (Check only one)

Physician /Medical Examiner

0

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examinar must be notified at

semit. Peges 1 and 2 should be filed within 72 hours efter or Department of Health and Mental thygiene. If tem 27 is marked other than "natural", or item

altimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

with the Merylend

death

Examiner Physician/Medical à Completed Be Lo Certification:

buriel-transit end ettending physician for use es the burie 98 signed by d be detect peeu hes page 2 certificate director, funeral

The law requires that the death certificete be executed Hospital or Attending Physician:
 24 hours after death,
 Funeral Director: After this certifica filled in by To the Hosp within 24 hor To the Fune completely fil

> State Registrar

31. Date filed (Month, Day, Year) APR 0 5 1999

25. Was case referred to medical examiner?

29b. Signeture and title of certifier

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Deeth

1 Naturai

2 Accident 3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29e. Certifier

Medical

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) BEATRICZ F. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, 32. Régistrar's Signature BARRE

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28a. Date of tnjury (Month, Dey Year)

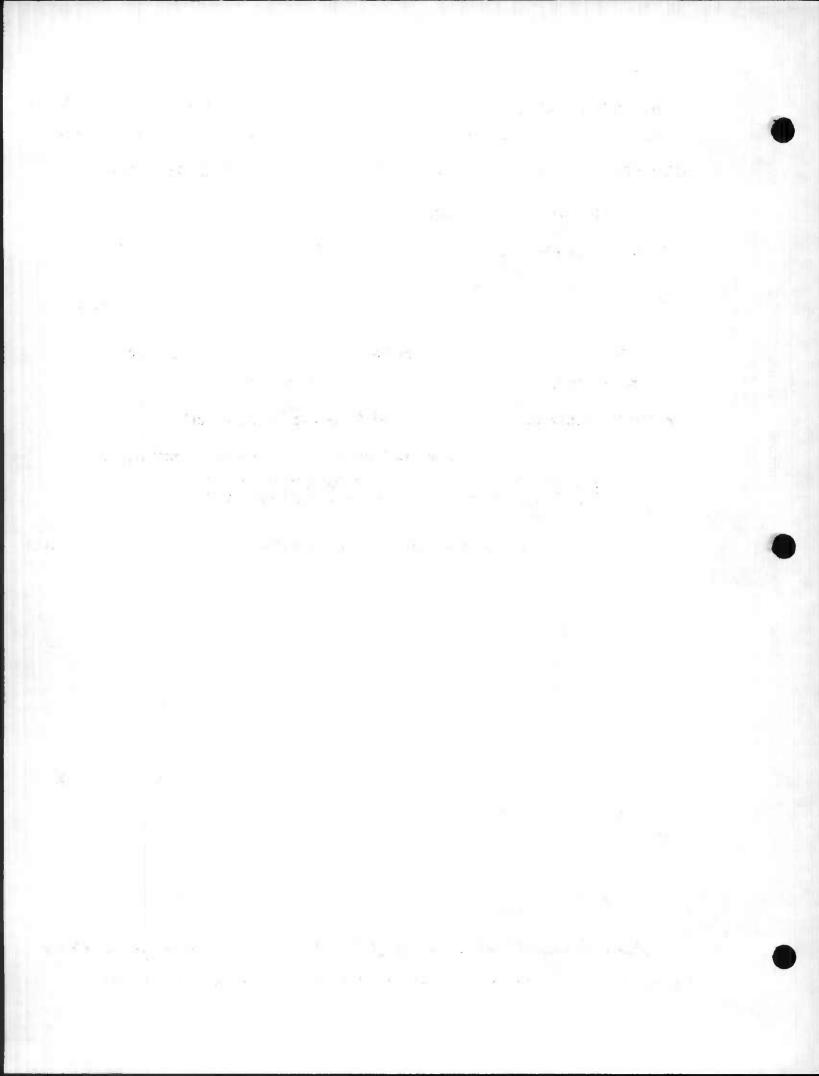
28c. Injury at Work?

1x Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner stated.

29c. License number

1 Tyes

2 No



Pleas

	Plea	ase Type or	Print In Black Inc	delible	lnk.	Assu	ire A	II Coples A	re Le	gible.			
		State	of Maryland / Depa	artment <i>tificate</i>					ene	9	109	84	
1. Decedent's Nam	e (First, Midd	le, Last)						2. Date of Death Month	Day	Year	3. Time o	ot Death	
WII	LIAM	FRANCES	CREIGHTON					April	- "	L999	3:15	P.M.	
4e Facility Neme (If not institution	n, give street end nu	ımbər)		4	lb. City, To	wn, or L	ocation of Deeth	4c. Cou	nty of Deeth			
Presbyte	rian H	Tome of Ma	ryland			Tows	son	_	Bai	Ltimo	re		
5. Social Security N		6. Sex	7. Age (In yrs. last birthday)	If Under 1	-	If Under		8. Date of Birth (Month, Day,			nplace (State untry)	or Foreign	
215-07-8253 1□ M 2XF			93 Yrs.	Months	Days	Hours	Min.	Jan. 30.	1906	Mary	land		
Usuel Residence o	Decedent												
10a. State 10b. County 10c. City, Town or Lo				cation							10d. Inside (City Limits	
Maryland Baltimore Towson											1 🗌 Yes	S 2V No	
10e. Street and Number				10f. Zip (Code			10	. Citizen o	of What Co	untry?		
400 Georgia Court					2	1204			U.	J.S.A.			

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

14. Race - American Indien, Black, White, etc.

White

Specify:

Own Home

18. Mother's Name (First, Middle, Maiden Sumeme)

Frances Powell

16b. Kind of Business/Industry

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Maryland

George

1 Never Married 2 Married

3 Widowed 4 ☐ Divorced

Elementary/Secondary (0-12) 8 Years

17. Father's Name (First, Middle, Last)

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give

College (1-4or 5+)

Usilton

death with the Maryland

Nam 27 is marked other then "natural", or hema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglena. Intervantant: If Itam 27 is marked other than "natural", or fleat any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner attending physician and Physician/Medical by Completed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be Certification: To Medical

Division of Vital Records, P.O. Box 68760

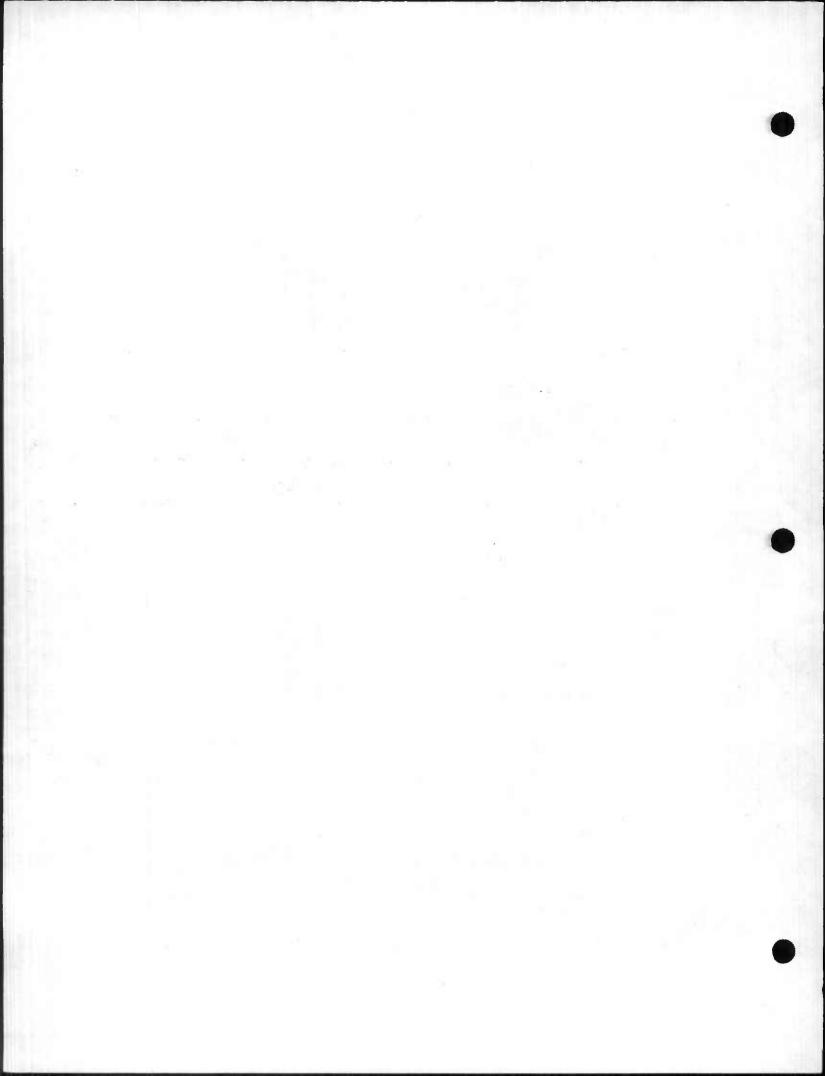
19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Duell 400 Georgia Court Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Church Hill Cemetery 4-7-99 4 Donation 5 Other (Specify) Church Hill, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mumonga 10 dass Due to (or as a consequence ot): Sequentielly list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ♦ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number Attending 37016 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print)

Kennth M. Greene, no 6701 N. Charles St., Suite 4105 3=14more, no 21204

State Registrar

31. Date tiled (Month, Day, Year) 6 1999 32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #1 PER MD G770 4-13-99 WR. Certificate of Death ITEM: #14 PER F.H. G770 4-13-99 WR Decedant's Name (First, Middla, Last)
 MARGARE I 2. Data of Daath 3. Time of Death Month **Physician** 2, 1999 MARAGRET EMICH COMPTON April 4:43 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore County Hospice of Baltimore: Gilchrist Center Towson If Undar 1 Yaar If Under 24 Hrs. Hours Min. 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sex 8. Data of Birth (Month, Day, Year) **Funeral** Months 1□M 2MF Days Director 212-03-6520 86 Jan 7, 1913 Maryland Usual Rasidence of Decedan 10a. State 10c. City. Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore County Directo Parkville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? b event the Medical Examiner must be Items 23s #1307 Funeral 8820 Walther Blvd, 21234 USA 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 No Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien. Black, Whita, atc. 1 Nevar Married 2 Married 'natural', or Specify: USA-WHITE If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: by 3 Widowed 4 NDivorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Baltimore City then Elementery/Secondery (0-12) Collaga (1-4or 5+) Hygiene. Secretary to City Solicitor Civil Service 11 th 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Peges 1 end 2 should be fit Department of Health and Memail H Important: if item 27 is marked oth any injury or other traumatic even Be John Andrew Emich 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Ralationship (Type, Print) Carolyn E. Feige (Daughter) 18 Holly Branch Ct., Glen Arm, MD 21057 Baltimore. 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Buriel 2 Crametion 3 Ramoval from Stata 4/6/99 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episc. Ch. Cem. Long Green, Maryland 21. Signature of Funeral Service 2 22. Nama and Addrass of Facility Martin D. Mitchell-Wiedefeld Funeral Home, Inc. auson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 approximate shock, or heart failure. List only one ceuse on each line. Intarval Batween Onset end Deeth **Physician** Immediate Cause (Final disaesa or condition rasulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Lest ettending physician and for use es the bunal-tren Due to (or es a consequança of) Box 68760 death certificate be axed Due to (or es e consequance of) P.O. 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. The law requires that the 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara eutopsy findings availabla prior to completion of cause of daath? Completed 24a. Was an autopsy peen After this certificate hes page 1 Yas 2 No 1 ☐ Yas 2 ☐ No rs after deem. rai Director: After this cen... Physician: 25. Wes case rafarred to medical Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) To 1 Yas 2 No 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: Injury at Work? or Attending 1 Neturel 2 Accidant 5 Pending invastigation 1 Yas 2 No 6 Could not be determined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 T Homicide within 24 hours a To the Funeral C completely filled 29a. Cartifian 15 Certifying Physician: To the best of my knowledge, daath occurred at tha time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29d, Date signad (Month, Day, Year)
APr. 13, 1999 29b. Signature and TNe of bert 29c. Licansa number

State Registrar 31. Data filad (Month, Day, Year) 6 1999 32. Ragjstrar's Signatura merra.

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30. Nama and addrass of person who complated carried death (flow 200) Pype, Print)

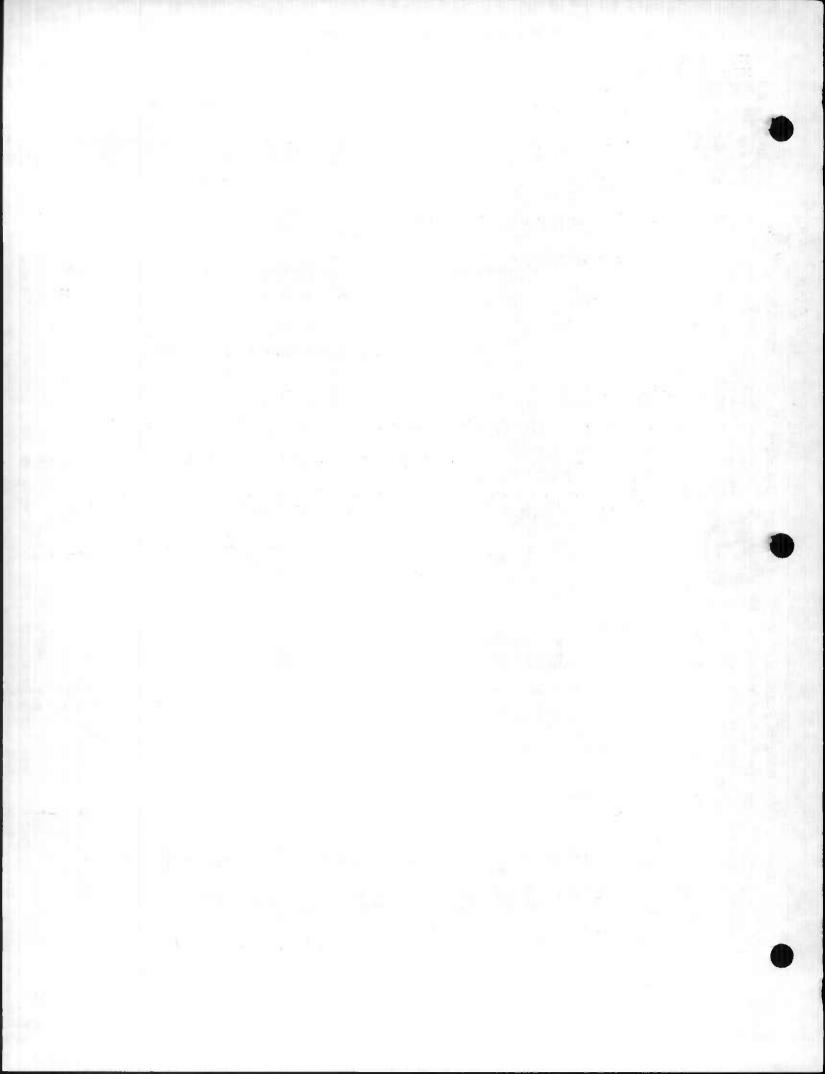
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHERICO 4:12 Pm ATHERINE MARCH /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University BALTIMORE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) of 7. Age (In yrs. last birthday) ff Under 1 Vear 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Funeral Days Months I 1 M 2 F 215-22-2425 18,1926 Director Usuel Residence of Decedent the Menyland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examinor invest be notified at WYes 2□ No Director BALTO. 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 ST, Funeral 21230 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene.
Important: if item 27 is marked other than "natural," or item any injury or other traumatic event, the Medical Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced Yaar or Datas 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (7-4or 5+) to memaker OWN HOME 10 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SPERANZELLA 19e. Informent's Neme/Reletionship (Type, Print) DNEETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty NICCE NADOLNY 1007 m. FAWN BALTO, 21202 510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) PAUTO, Md Metro CREMATORY 21. Signature of Funeral Service Deensee 22. Name end Address of Fecility
DELLA NUCE
322 S. Hick FUNDANC HOME BUTO 500 Lifter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on aech line. Approximate Interval Between Onset and Death **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical Sepsis Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of) Box 68760, that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Be Completed 20100 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; p. 25. Wes case refarred to medical 26. Place of Deeth (Check only one) examiner? 1□ Yes 21 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending invastigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e Certifier

State

Registrar

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

Burks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registar's Signature

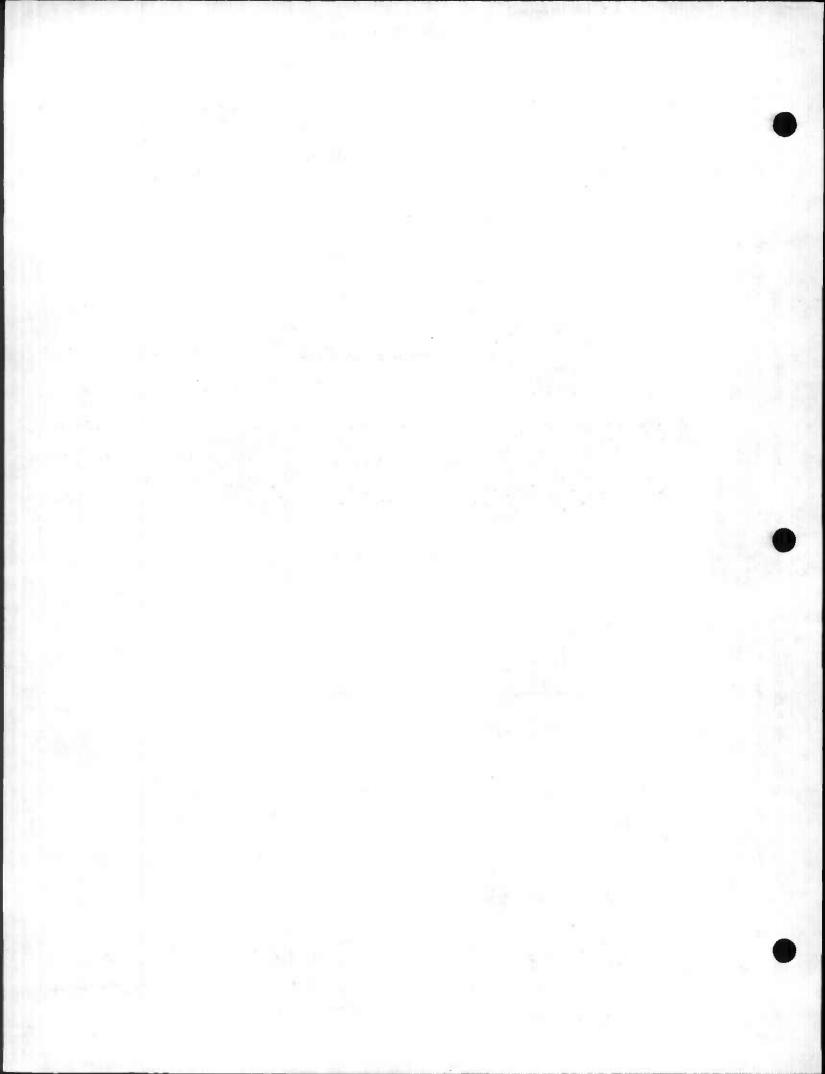
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29c. License number

29d. Date signed (Month, Day, Year)

22 5 Greene St. Ba Hinore, MD 21201



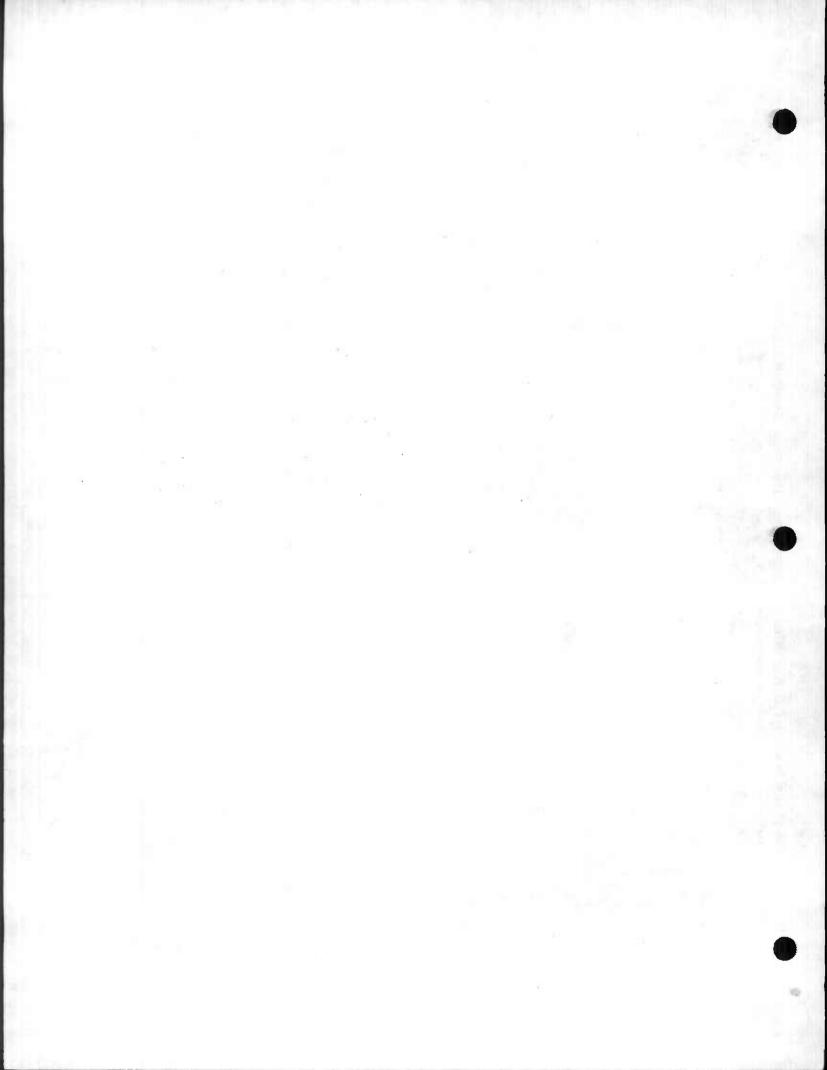
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 1999 APRIL Beatrice M. Dunn 02, 5:25 PM /Medical 4a Facility Nama (It.not institution, give street and number) 84 N. Old Mill Bottom Road Colonial Manor The Annapolitan 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE 29, 1 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 10 M XDF Yrs. 75 074-18-8702 1923 Director New Usual Rasidance of Decedant 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or hama 23a or 28a-1 show the Medical Examiner must be notified at 1 Yas X No MD Anne Arundel Annapolis 10e. Street and Number Colonial 84 N. Old 10f. Zip Code 10g. Citizen of What Country? 늅 The Annapolitan Bottom Road 21401 USA Funeral 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status hours after 1 Nevar Married 2 Married 1 ☐ Yas 2 🕅 No If Yes, Giva Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within 72 Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) School Teacher New York Public Schools permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event once. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Barnett Melamed Ida Shavitz 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Barbara Walkowich/daughter 668 Teton Drive Lothian, MD 20711 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from State 04/03/99 4 Donation 5 Othar (Specify) Metro Crematory, Inc. Baltimore, 21. Signatura of Funeral Sarvice Licensec 22. Name and Address of Facility Cremation Society of Maryland, Inc. Day Time Homald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** with Brain Metasais 9 mo /Medical tmmediata Causa (Final disaase or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case refarred to medical axaminar?

1 Yas 2 No Be 26. Place of Death (Check only ona) Other: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Natural 4 hours after deeth. Funeral Director: After ony filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. edical (Check only one) 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier)usbour mo 1)38563 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Wayne D. Bierbaum, my Kd Owe no ville 134 31. Date filed (Month, Day, Yaar) 32. Registrar's Śignatura State Registrar naned 6 1999



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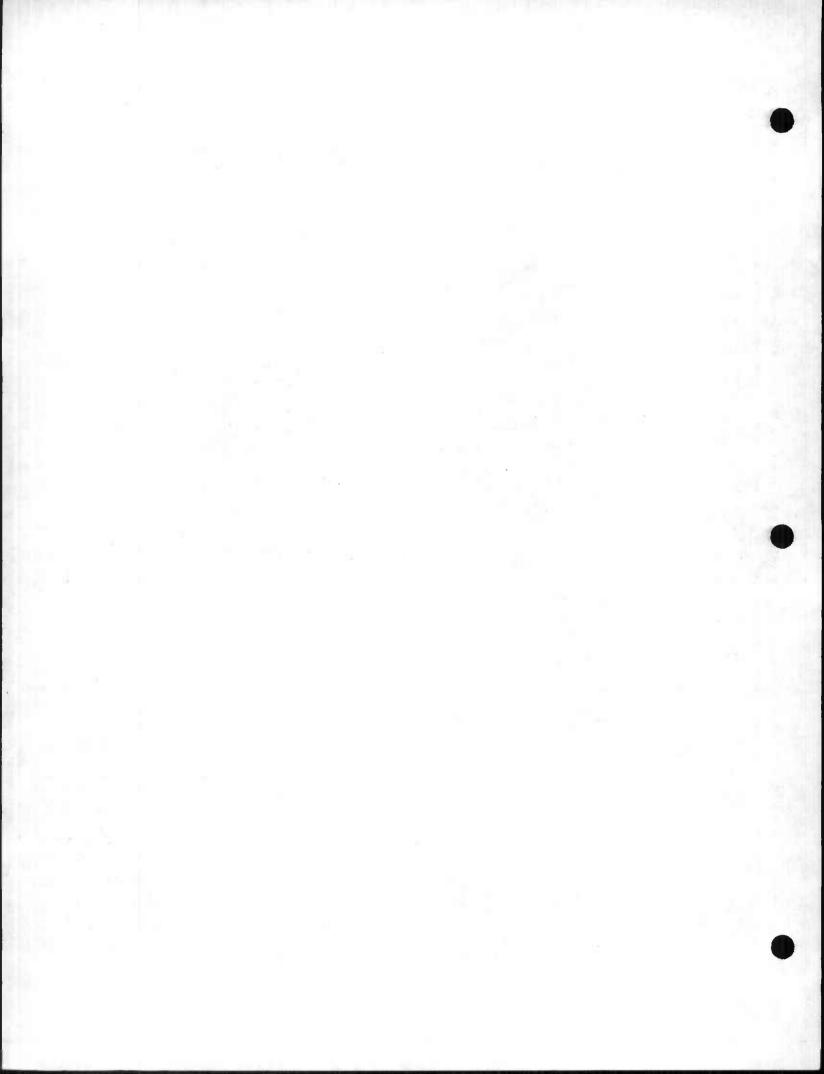
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/Medical Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, o	Location of Deeth		
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lo	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HDDL Drum B. VO Luc VM . 111	Penn Street	, Baltimo	re, Marvl	and 21201
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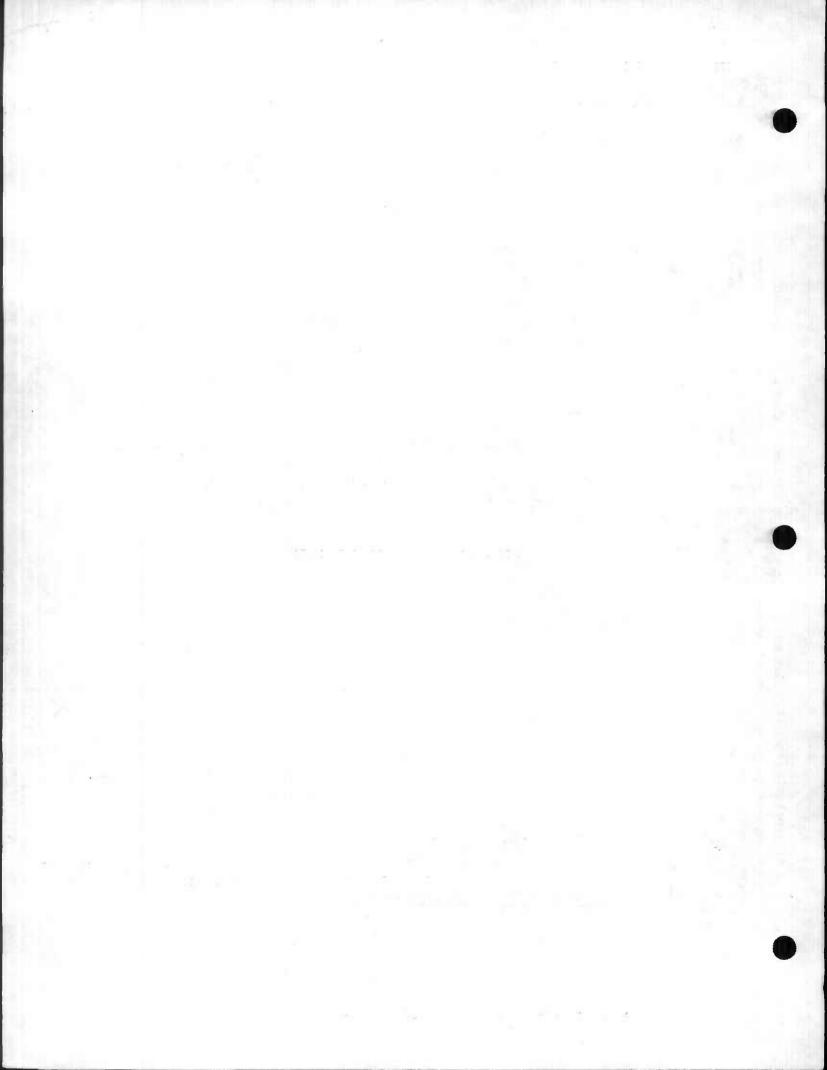
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DHMH 16 Rev 6/95

State

Registrar

APR 0 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 921 Am March Philip J. Dilworth /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deetl Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex Birthplece (State or Foreign Country) 1 X M 2 □ F Months Fork, Maryland Nov.16,1925 214-20-0437 Usuel Residence of Decede 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo BelAir Maryland Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 14. Rece - American Indien, 108 McCormick Street 21014 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 No Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 yrs. Truck Driver Trucking Industry n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be David Burgan Dilworth Florence Isabelle Fitzpatrick 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Timothy B. Sullivan (Nephew) 915 Wheel Road BelAir, Maryland 21015 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Stephens Church Cem. Bradshaw, Maryland 21021 4/3/99 21. Signeture of Funeral Service Light 22. Name end Address of Fecility E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Applications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Applications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) PERIPHERAL CIRCULATORY Due to (or es e consequence of). Examine Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): BRONCHO PNEUM ON IA BIL ATERAL Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were eutopsy findings eveilable prior fo Completed 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28a. Date of injury (Month, Day Yeer) 27. Menger of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) end manner stated. 29a. Certifier edical

that the death certificate be executed SI WOTH Philip or Attending Physician: efter death. Director: After this certific To the Hospi within 24 hou To the Funer completely fil

24 hours

Funeral

Director

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Physician /Medical

Examiner

physician end the buriel-transit

attending pl

signed by the a

page 2 s

Peges 1 and 2 should be nent of Health and Mental

Health a

the Maryland

filed within 72 hours efter death with

Baltimore, Maryland 21215-0020

Registrar

YANKAR M.

29b. Signature end title of certifier

MD

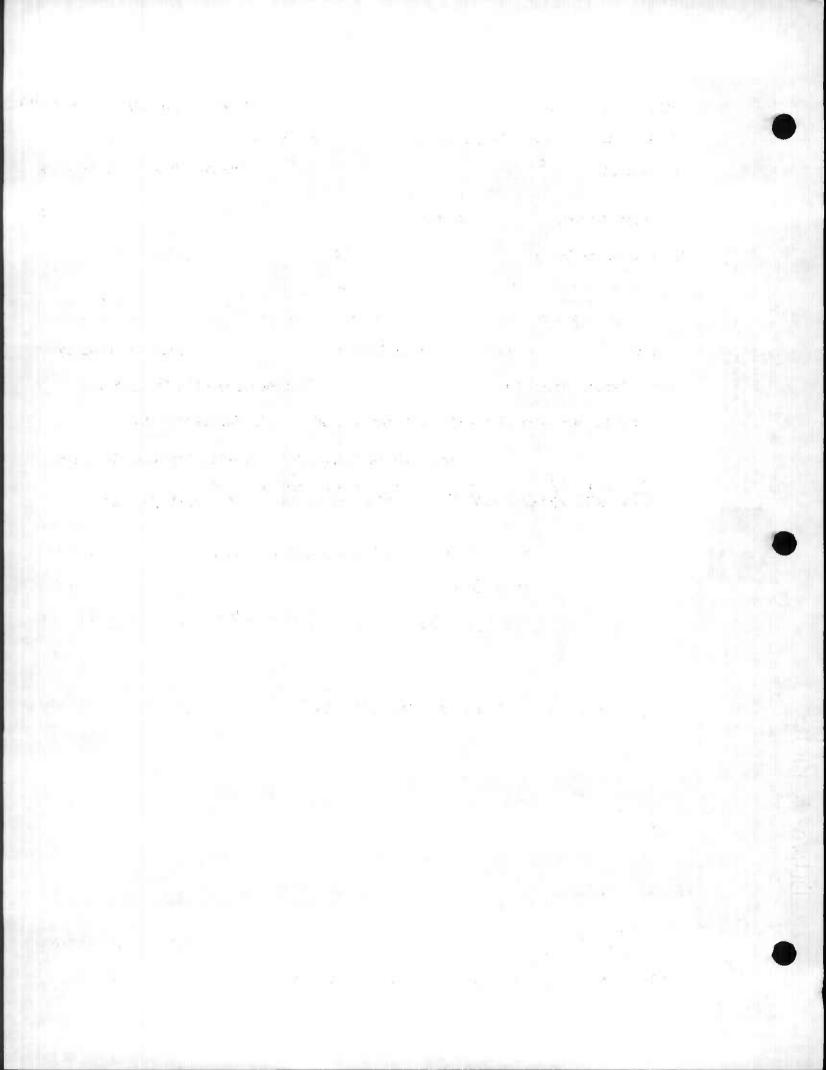
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EVENUE BEL AIR MD 21014 2 NORTH

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture APR 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decadant's Name (First Middle Last)

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be published at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death centricete be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

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	William Kight						Marg	aret	Fisk					
	19e. Informent's Name/Relationship (T	ype, Print)		19b. Meiling	g Addrass	(Street e	and Number	or Rure	Route Numb	er, City	or Town, s	Stete, Zip	Code)	
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Ì	20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Plec	a of Dispos	ition (Nen	ne of		1	Date				wn, Stete	
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	thet initieted events	C	Due to (or es	e conseque	ence of):							-		
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		Danding, etc	. (Openy)						Ony OF TOV	···, Stell	,			
1	29a. Certifier Certifying Phys	sician: To the best of	of my knowled	dge, deeth d	occurred e	et the time	e, dete end p	place, er	nd due to the	ceuse(s)	end men	ner as st	eted.	
1	(Check only 2 Medical Examinate)	ner: On the besis of end mannar ste	examination	end/or inve	stigation,	In my op	inlon, death	occurre	d et tha tima,	dete end	plece, a	nd due to	the ceuse(s)	
1	29b. Signature end titla of cartifier				29c.	Licensa	number			29d. Da	a signed	(Month, I	Day, Year)	
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1	30. Name and address of	ampleted assets	anth Otto	a) (T = 5						. 44		0.01	(11)	
1	30. Nama end eddress of person who co	impleted causa of di	aeth (Item 23	e) (Type, Pi	rint)									

Ronald J. Shumacher, MD - 2309 Shorefield Road - Silver Spring, Maryland 20902

32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year DOW **Physician** VIOLA APRIL 11:25 PM 1999 /Medical City, Town, or Location of Deeth Fecility Neme (If not Institution, give street and number 4c. County of Death Examiner Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Hours 1 M 2 F Yrs Director Usuel Residence of Decadent with the Maryland City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show solded Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g, Citizen of What Country? 10f. Zip Code 1236 permit. Peges 1 and 2 should be filed within 72 hours after deeth 1 Department of Health end Mentat Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Mexical Examiner mans any Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic event, the Mexical Examiner mans and Injury or other traumatic events. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. 12. Was Decedent Eyer in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: la by Specify: 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) nestic 17. Father's Name (First, Middle, Last, Be manue 19a. Informant's Name/Relationship (Type aughter 20c. Location, City or Town, State 20a. Method of Disposition 1 W Buriel 2 Comation Other (Specify) 4 Donation 21. Signeture of Pu eral Service Licel rilton ase, of complications that caused the deeth. Do not enter e. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel BACTEREMIA NEGATIVE GRAM 2YAC disease or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner INFECTION HEMOCATHETER Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificaters Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 🎁 Unknown NEGATIVE AND MRSA PNEUMONIA þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed ABETESMELLITUS WITH VASCULOPATHY NEUROPATHY AND NEPHROPATHY, ves pege 2 s AND STAGE 2 X No 1 ☐ Yes 2 ☐ No REVAL certificata 32A321C or Attanding Physician: director Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending To the Hospital or Attandir within 24 hours efter death. To the Funeral Director: Af completaly filled in by the fu 1 Yes 2 🗆 No efter death. 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) and manner as steted. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and manner steled. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number al le Rauf

State Registrar

31. Date filed (Month, Day, Year)

32/Registrer's Signature 0 6 1999

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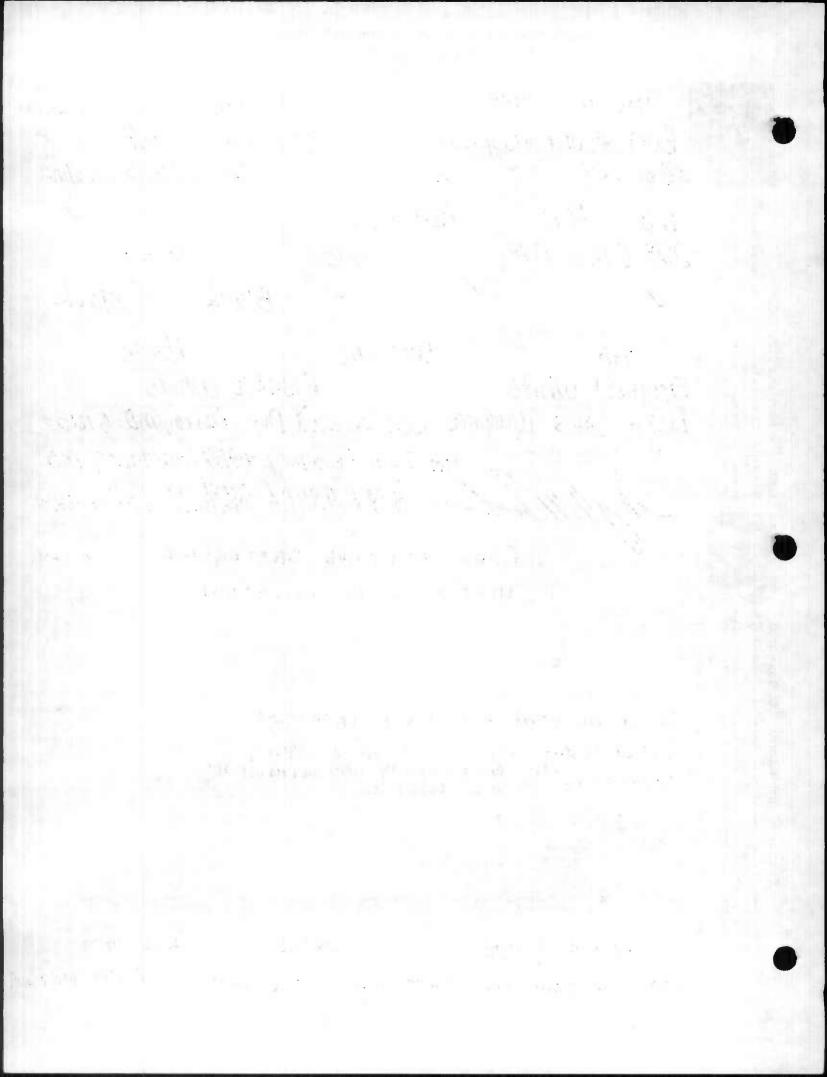
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30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

, wilkens

D18362

Ave. Suite 308, Balto. Md2/229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ,25 PM MABLE EDWARD 6 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death HIMORE MARYLAND EVINDALE If Under 24 Hrs. If Under 1 Year Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 1□M 200 Months Deys 212-30-277 Hours 94 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Tes 2 No BALTIMORE 227C 101. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 WINDSOR USA GATDEN 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Black Specify: Year or Detes: 3 ≥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) PRIVATE DUMESTIC mile 6 1 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Horgan LUSEPHIDE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Country Blue HE HARLES Watts 920 1055 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete cametery, cremetory or other place) Burial 2 Cremation 3 Removel from Stete Burial 2 Other (Specify) oro Notronal Monoral Forte 22. Name and Address of Fecility 22. Name and Address of Fecility Chita Try An - How 5240 Red STERTUW Rong 23a. Part 1. Enfar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, about or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part IJ-Qther eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 0 No 3 Probably 4 Unknown Deviphere 24b. Were autopsy findings available prior to completion of cause of death? Vascular diseas 24a. Wes en eutopsy 20 NO 1 Yes 1 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 5 Pending Investigation

Examiner attending physician end for use as the burial-transit Box 68760. Physician/Medicai P.O. signed li Records, Be Completed by certificate Division of Vital oapital or Attending Physician:
hours after death.
neral Director: After this certifica
ly filled in by the funeral director, I Medicai Certification: To

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or frame 23s or 28s-f show the Medical Examinar must be nutfred at

permit. Peges 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "pay Injury or other traumatic avent, the Mode.

Physician /Medical

Examiner

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Baitimore, Maryland 21215-0020

Director

Funerai

by

Be Completed

1 Naturel

2 Accident

4 - Homicide

3 ☐ Suicide

29a. Certifier

29b. Signature av

28d. Describe how injury occurred

28c. Injury at / Work? 28b. Time of 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29c. License number

29d. Date signed (Month, Day, Year)

30. Nemmend address of person who completed cause of death (Nem 23a) (Type, Print)

Indale

State Registrar 31. Dete filed (Month, Dey, Year) 6

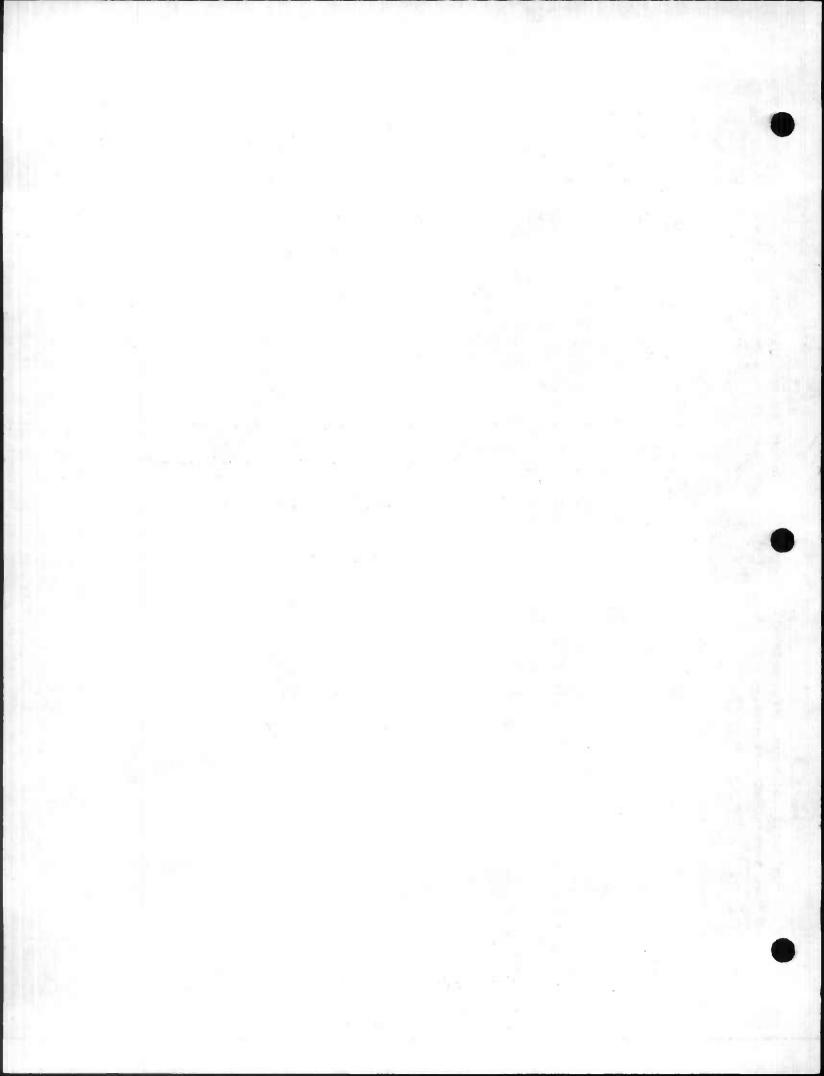
d time of certifies

6 Could not be determined

32. Begistrer's Signeture

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

To the Hospital or A within 24 hours after To the Funeral Dire-completely filled in b



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month, **Physician** 00 TILDA 1999 APRIL /Medical 4e. Fecility Neme (If not institution, give street end numb 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner OAKCREST VILLAGE CARE CENTER If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month, Dey, May 24, BALTO BALTO 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Funeral 1□M 2XF Maryland 91 Yrs. Director 213-12-0092 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes 2 No Directo Maryland Baltimore Parksville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 8830 Walther Boulevard Apt T006 Items 23a 21234 U. S. A. Funeral Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yas, Give Year or Detes: 8 1 ☐ Yes 2 🕱 No Specify: by 3 Nidowed 4 Divorced Specify White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 8th Grade Own Home marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 90 and Mental Anthony Wieczynski Lucy Biniasz 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Important: If item 27 is any injury or other trau William John Ey (Son) 65 Campbell Court, Conowingo. Maruland 21918 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Locetion - City or Town, Stete 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Stanislaus Cemetery 4/8/99 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Schimuner Funeral Home Inc. Mark T. 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart fallure. List only one ceuse on each lina. Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immediete Ceusa (Fine asc disease or condition rasulting in death) **Examiner** Examiner ARS e ns physician and s the burial-transit that the death certificate be axecuted Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as e consequence of): for use as Pert II. Other eignificent conditions contributing to/deeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 11 N6 TR signed b ρ Records. 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Be Completed this cartificata 1 ☐ Yes 2 ☐ No Vita 25. Was cese referred to medical examiner? 26. Plece of Beeth (Check only one) 2514 Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA of 27. Menner of Deeth 28e. Data of Injury (Month, Dey Year) Hospital or Attending P1
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| Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end prannar statad. edicai 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Dey, Year) nd address of page cause of deeth (Itam 23a) (Type, Print)

M. D. 8800 WALTHER BLVD. PARKVILLE

State Registrar REDRIC

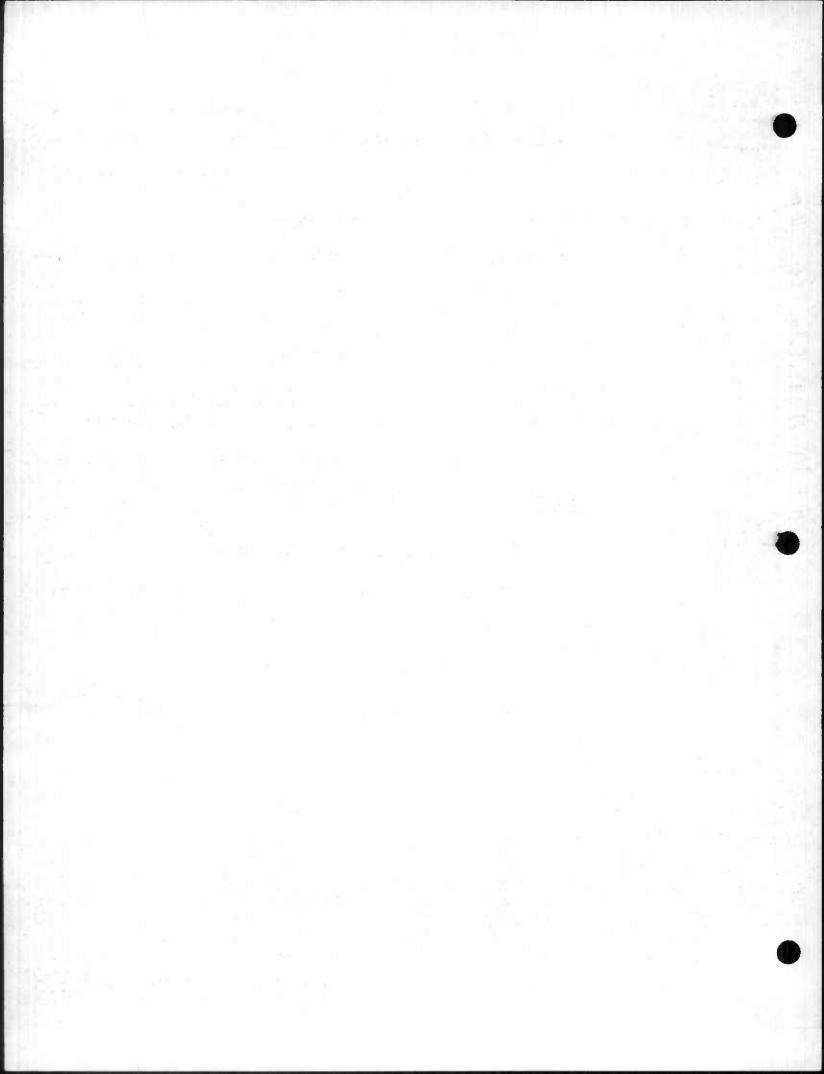
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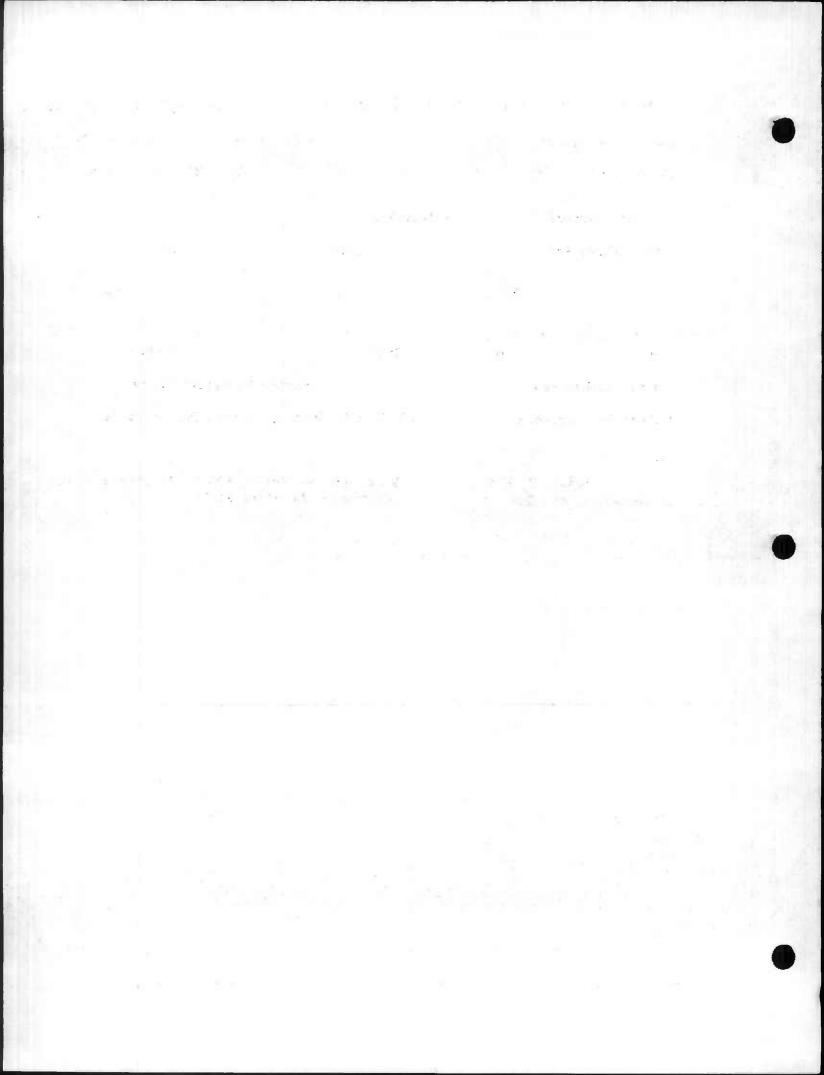
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 0996 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mar. 29, 99 10:25pm Jennie Fincher Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BonSecour Hospital Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-31-03 5. Social Security Number Birthplace (Stete or Foreign Country)
 VA 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days 1□ M 2√ F Yrs. Director 216-10-7329 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore Yes 2 No Director notify . 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barra 23s or 1606 Chesapeake Avenue 21226 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married 'natural', or altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: 3€ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 ahouid be illed within 7 Department of Heath and Mental Hygiens. Importants if Nem 27 is meriked other than "y any Injury or other treatmetic event, the Mad and and a page 2. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade 2yrs. Insurance adjustor Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 Nathaniel Simmons Emma Watson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 19a. Informant's Neme/Relationship (Type, Print) Larry Heath 2714 claflin Court Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State Arbutus Mem. Pk. Cem. 04-07-99 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Ligensee Baltimore; Maryland 21202 Ma WM.C. March FH1101 E. North Avenue 1000 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) . Preumonia with Loculated Pleural Examiner Due to (or as a consequence of) Physician/Medical Examiner Husion attending physician and for use as the burial-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760, 20005 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown tailure to I hrive Records, þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Dementia completion of cause of death? Anemia 1 ☐ Yes 2 ☐ LNc 1 Yes 2 No certificata Division of Vital Attanding Physician: 25. Was cese referred to medical examiner? B 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tyes 2 No To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completaly filled in by tha fi 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide edical 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

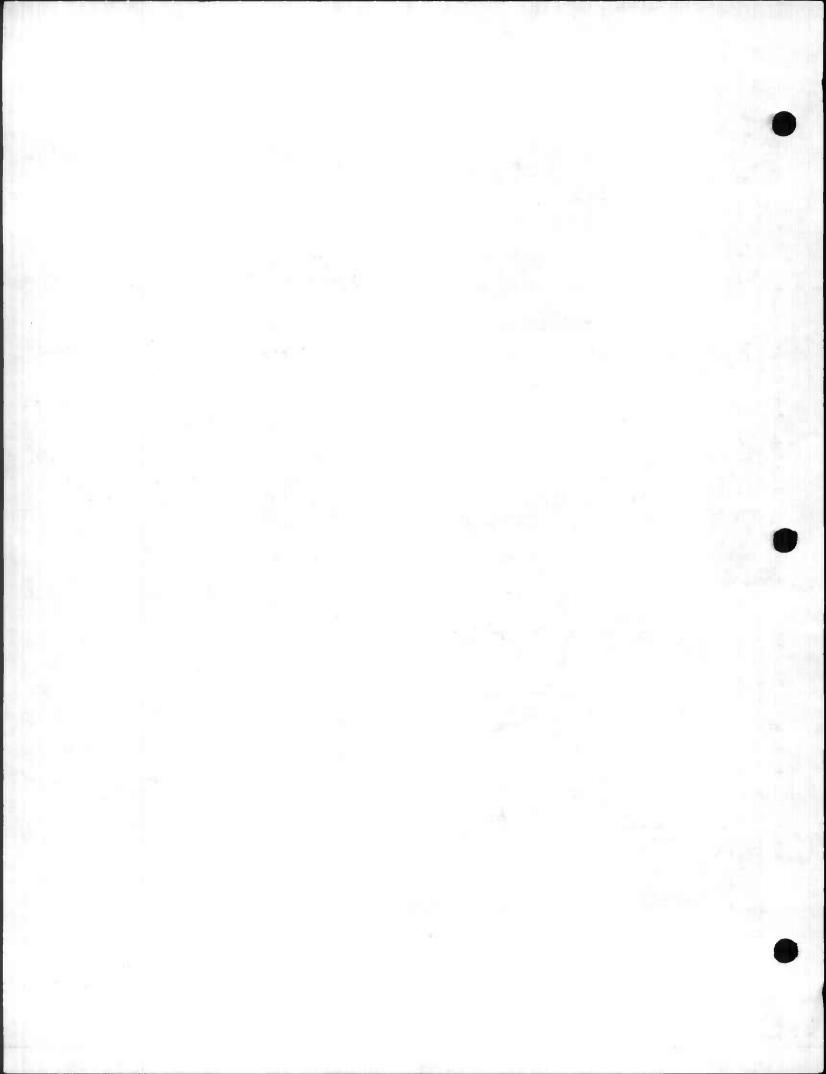
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier andex (lemnors) MS 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WANDAUT Simmons Clemmons mo 2513 Cleanleigh Drive Bult me 21234

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature



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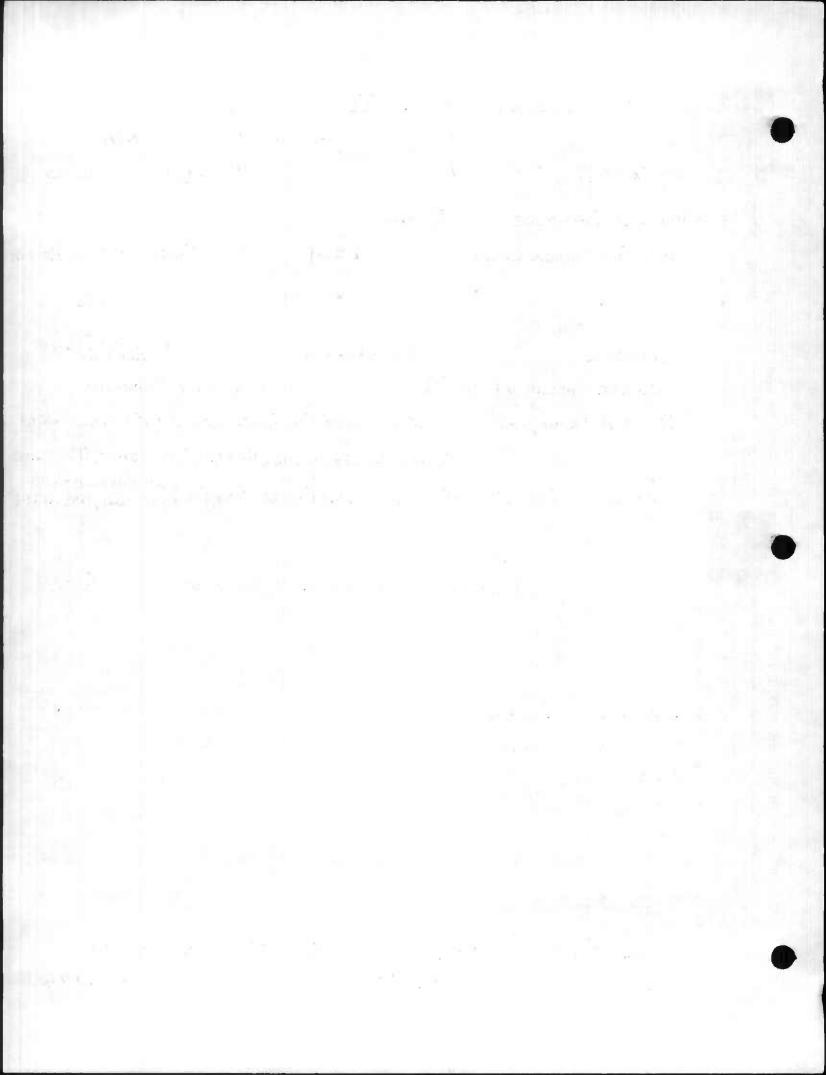
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SHELLMAN trank 1:12 AN heodoRE 1999 April /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 47 NIA Hospital BaltiMORE SAMAritaN 6000 If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 79 216-28-6057 Yrs. MARYLAND **Director** Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examination must be notified as BALTIMORE 1 Tyas 2 No MARYLAND TOWSON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1003 SOUTHWICK COURT UNITED STATES OF AMERICA 21204 e filed within 72 hours efter death val Hygiene. other than "natural", or items 23 Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HALL'S MOTOR TRANSIT Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER GTH GRADE TRUCKING parmit. Pagas 1 and 2 should be file Depertment of Health and Mental Hy important: If item 27 is marked oths any hijury or other traumatic event, pncs. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) VIRGINIA SHANKLIN SHELLMAN FRANK, JR HEODORE CARRIE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 6711 CHERRY HILL ROAD / BALDWIN, MARYLAND 21013
ce of Disposition (Name of Date 20c. Location - City or Town, State JAMES A. FRANK, 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition DULANEY VALLEY MEMORIAL APRIL8, 1999 COCKEYSVILLE, MARYLAND 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licensaa 22. Nama and Address of Facility 6009 HARFORD ROAD Gonald R. ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214 M. M00612 Watson, 23a. Part1. Enter the disaasa, or complications that ausad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on eech line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Sepsis Examiner Due to (or as a consequence of): Examiner Infection URINARY 11cro(o((VS TracT attanding physician end for usa as the buriel-transit requires that the death cartificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical Due to (or as a consequence of): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Prevmonia by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been: Pankinsons DISEASE aw has The chronic CVA 1 ☐ Yes No 1 ☐ Yes 💥 No cartificete 25. Was case referred to medical examiner? Physician: funeral director Be 26. Plece of Deeth (Check only one) Hospital: 1 Phopatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) O 1 Yes 25 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Natural or Attending 5 Pending daeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) In by eftar 4 Homicide Funeral Distalled in Itself Hospital 150 Certifying Phyalcian: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier complataly (Check only one) within 2. 29b. Signature and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Borkvard Baltimar = MD AlgiN 560 / Loch Raven M.D

State Registrar 31. Dete filed (Month, Day, Year)

0 6 1999

22. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year ELIZABETH FLEMKE April 2:45am 1999 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street and number) 4c. County of Deeth 418 Essexwood Court Essex Baltimore 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept.13 1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M ZOXE Months Days Hours Min 142-05-7805 81 Yrs New Jersey Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Essex 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 Essexwood Court 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 22 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing 12th Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) FRank Oltman Elizabeth Kulczar 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Flemke /daughter 418 Essexwood Court Baltimore Md. 21221 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Md. 21. Signature of Funeral Service Licensii 22. Name end Address of Facility Connelly Funeral Home of Essex erry 300 Mace Ave. Baltimore Md. 21221 e mode of dying, such as cardiac of respiratory arrest, Approximate tnterval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Obstructive Due to (or as a consequence of): ohlacco Depen denc Caus Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 □ No 3 Probably 4 Unknown Osteuporosis Depression COLONALY Artay 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy Serse 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 (XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide

Examiner requires that the death certificate be assect P.O. Box 68760,5 the 88 USB 0 signed by the a Records, page 2 s certificate Division of Vital or Attending Physician: director. this funeral After after death.

Physician

/Medical

Examiner

Funeral

Director

must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene.

Int: If items 72 Is marked other than "natural", or items 23, mit; if items or items in the other traumatic event, the Medical Execution mustry or other traumatic event, the Medical Execution mustry.

Department o important: If i eny injury or

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

with the Maryland

Physician/Medical P Completed To Certification:

edical

29a. Certifier (Check only one)

To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

APR

29b. Signature and this of certifier

MO

29c. License number 0506

MO

91921

29d. Date signed (Month, Day, Year) 199

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

HOPKINS-Bauplau 5505 31. Date filed (Month, Day, Year)

32. Registrar's Signature signers. 6 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month maggie Garrett 3 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Irvington Knolls Care Center Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | 74 | Wre | Months | Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 K F Hours 214-56-0520 North Carolina Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Baltimore Maryland None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3005 Glen Ave. 21215 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No if Yes, Give Year or Dates: 14. Raca - American Indian, Bleck, White, etc. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Homemaker private home 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) William Garrett Narcissus Wallington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3065 Glen Ave. Baltimore, Maryland 21215 George Garrett - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4-6-99 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death Immediate Cause (Final Ather sclentic randiovascular disease disease or condition resulting in death) Due to (or as a consequence of) Renal failing Due to (or as a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medicai Examiner

and

physician

signed by t

certificate

funeral

in by

• Hospital or Attanding Physician: 24 hours efter death. • Funeral Director: After this certifica

To the I

Box 68760.

P.O.

Division of Vital Records,

Examiner

Physician/Medical

by

Completed

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral', or itams 23a or 28a-f shov Examiner must be notified at

2 should be filed within 72 hours effer and Mental Hygiene.

Is marked other than "natural", or in

permit. Pages 1 end 2.
Depertment of Health ar Important: If Item 27 Is.
any Injury or other traus

other traumatic event, the Madical

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

the Marylend

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25.	Was case		to medical
	examiner?		
	1 Yes	2 1 No	

5 Pending investigation

6 Could not be determined

28e. Date of injury (Month, Day Year)

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28c. injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

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27. Manner of Deeth

1 Naturei

2 Accident

3 Suicide

4 - Homicide

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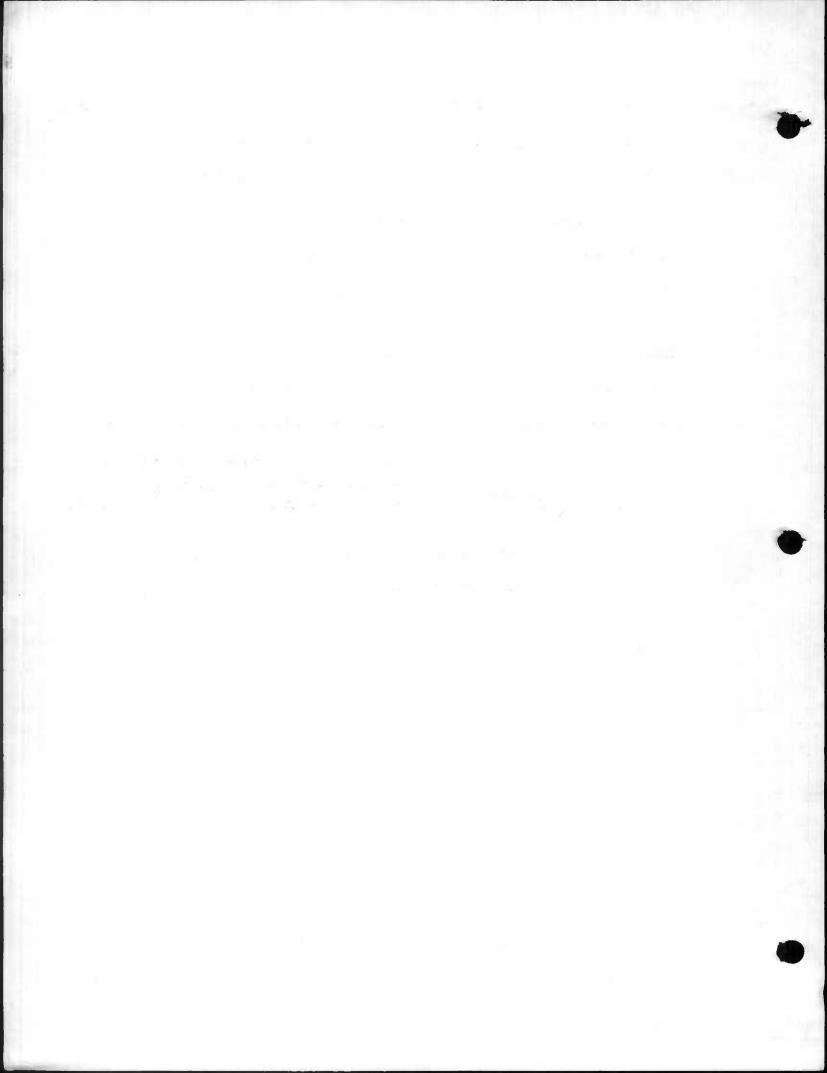
Entaw street Boet md 2/20,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mier - Dog 31. Dete filed (Month, Dey, Year)

Rm 206 32. Registrer's Signeture

State Registrar



	1.	Decedent's Name (Fir.	st, Middle, La	st)	770 4-6-9	9 WR.	tificate o	Death		2. Date of De	Reg. No.		3. Time of Death
hysician /Medical		Waltir	na L	. Gral	nam					Month Mar.	2.7	Year QQ	5:32AM
Examiner		Facility Name (If not i	-					4b. City, To	wn, or Loc	cation of Deat		ty of Death	
				erry A			Milleder 4 Ver	Balt:			NA		
uneral rector	L	Social Security Number 220-74-82 sual Residence of Dece	291 1	Sex I□M 2DXF	7. Age (In yrs. I	(ast birthday) Yrs.	Months Day		Min.	8. Date of Bir (Month, De 10-0		9. Birthp Cour	elace (State or Foreign htry)
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Completed		15. [(Specify on Elementary/Secondary 10th Grad	(0-12)	de completed) College (1	-4or 5+)	(Give I	ent's Usual Occ kind of work dor DO NOT use reti	ne during mos ired)	t of workin	99	16b. Kind of E	Business/In	
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once. To Be Comp		Walter 9a. Informant's Name/F	Relationship (Grahar Type, Print)	n	19b. Meilin	g Address (Stre		oth	4			ngton
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	re	nmediate Cause (Finel sease or condition esulting in death)		a		RCOTIC I	INTOXICAT	ION					
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